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HEALTH CARE FOR THE ECONOMICALLY DISADVANTAGED—II

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

SEPTEMBER 28, 1984

Printed for the use of the Committee on Finance

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HEALTH CARE FOR THE ECONOMICALLY DISADVANTAGED—II

FRIDAY, SEPTEMBER 28, 1984

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:37 a.m. in room SD-215, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senator Durenberger.

[The press release announcing the hearing, the opening statement of Senator Bob Dole, and a background paper by the committee staff follow:]

[Press Release No. 84-170]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON HEALTH CARE FOR THE ECONOMICALLY DISADVANTAGED

Senator Dave Durenberger (R. Minn.), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on the delivery of health care to the economically disadvantaged.

The hearing will be held on Friday, September 28, beginning at 9:30 a.m. in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing Senator Durenberger noted, that, "This is the second in a series of hearings to examine how to reach our goal of ensuring access to quality care. In many cases, those low income persons who are ineligible for Medicaid are 'falling through the cracks' of our health care delivery system. We began to address this problem with our first hearing on April 27, 1984. At that time we sought to determine who is economically disadvantaged and the extent of the economically disadvantaged population lacking access to health care. The purpose of this second hearing is to determine what services the economically disadvantaged are now provided, how those services are provided, and how they are financed. Later in the series of hearings we will focus on identifying what changes need to be made with respect to both the public and private sectors to ensure access to needed health care.

Senator Durenberger stated that the Subcommittee is interested in hearing from the Administration with respect to an overview of individual State's Medicaid eligibility, the scope of services provided and an overview of the other federally financed care provided through such mechanisms as clinics, and from the States as to whether and to what extent State programs are used to provide needed care. In this context, the Subcommittee would be interested in learning of any financing mechanism incorporated into a State rate setting system. Additionally, where care is made available through other than a Federal, or State financed program, the Subcommittee is interested in hearing from the entities that finance that care. This includes local government units, community service organizations, pubic and other community hospitals, physicians, clinics, and others.

OPENING STATEMENT SENATOR BOB DOLE

I want to thank Senator Durenberger for undertaking this series of hearings to examine the issue of access to health care for the economically disadvantaged. I believe that the Federal Government has been involved through the Medicaid Program block grants for health care and Medicare to name but few Federal efforts. However, the question still remains—have we done enough and should we do more? Before those questions can be answered we must know the extent of the uncovered population and have as complete an understanding as possible of the current mechanisms which finance and provide care—both public and private.

Through today's hearing we will attempt to gain that understanding. I know that there are a number of providers of care to the economically disadvantaged. I commend those providers, especially our public hospitals. Along with other providers, they help this nation meet the needs of the indigent and provide greater access to care than would otherwise be available.

I welcome today's witnesses. We look to you to tell us what is going on out there. Many of you are on the front lines and as such your views will be most helpful.

HEALTH CARE TO THE ECONOMICALLY DISADVANTAGED

Background Paper
Prepared for the Use of the Members of
the Senate Committee on Finance

September 1984

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HEALTH CARE TO THE ECONOMICALLY DISADVANTAGED

I. INTRODUCTION

The purpose of this hearing is to focus on the payment for and access to health care services for the non-aged poor or medically indigent who are not covered by private health insurance.

The uncovered population consists of two groups, the temporarily uncovered and those who are likely to remain unprotected for long time periods. The first group generally consists of persons who are unemployed and have temporarily lost their protection under their employment-based group health insurance plans. They can be expected to regain coverage when they become reemployed. The second group consists of those persons with no formal ties to the work force. These individuals are generally unable to purchase group health insurance coverage at affordable rates.

The uninsured are frequently categorized in terms of family income and/or employment status. This group includes persons who cannot afford private protection, persons who have lost protection as a result of unemployment, and persons employed less than full-time who do not have access to private group coverage. It also includes some employed individuals (such as the self-employed) who may not have access to affordable protection or are unable to purchase coverage at affordable group (versus individual) rates. In addition to the uninsured population, there is also the under-insured population. These are persons who have private insurance coverage but who are inadequately protected against the costs of a major illness.

Many of the uninsured and under-insured have some protection under a public program such as Medicaid. However, many persons fail to meet the requisite eligibility criteria and therefore remain unprotected. The actual number of persons without public or private protection is not known. Current estimates of the "uncovered" population range between 15 and 32.5 million persons.

The uncovered population use private physicians, public clinics and hospital outpatient departments for primary care. The uncovered population tends to use physician's and other noninstitutional services less frequently than their insured counterparts. Hospital inpatient services most utilized by this population are maternity and infant care services and services related to trauma, alcohol and drug abuse, and mental disorders.

Payment for services rendered to the uninsured is generally the responsibility of the patient. To the extent that these individuals cannot, or do not, pay for these services, it is referred to as "uncompensated care." Uncompensated care is defined as the sum of "free" or "charity" care provided to the poor uninsured population plus "bad debts" attributable to patients not officially classified as charity cases. The American Hospital Association estimates that community hospitals provided $6.2 billion worth of uncompensated care in 1982. This amount represents an estimated 5 percent of total patient revenues. Of this amount, $1.7 billion was classified as charity care and $4.5 billion as bad debts. Uncompensated care is not distributed evenly among hospitals. It is concentrated in public hospitals and in urban hospitals.

Hospitals may recover the costs of providing uncompensated care in a variety of ways. They may increase their charges, thus shifting these costs to third-party payers who reimburse hospitals on the basis of charges rather than costs. In some States, hospitals may obtain revenues from State-operated "uncompensated care pools." Public hospitals may also be able to recover their costs through State and local tax revenues.

Providers other than hospitals also provide care to uninsured patients. Some of this care is provided on a "charity" or "reduced fee" basis. No data is currently available describing the volume or types of care rendered.

II. SCOPE OF PROBLEM

A. Estimate of Uncovered Population

The Urban Institute estimates 1/ that the size of the uncovered population under age 65 was 30.7 million in 1981 and 32.7 in 1982. These numbers represent 15 and 16 percent respectively of the total number of persons under age 65 in those years. According to this analysis, the data show that income, more than any other personal characteristic, can be used to predict an adult's insurance status. In 1982, almost two-thirds of the uninsured (approximately 21 million persons) had incomes below 200 percent of the poverty level. The second most important determinant of health insurance coverage was the employment status of the adult family member. Among uninsured adults, just over one-fourth were full-time workers for 40 or more weeks in 1982. The data suggest that many of the uninsured adults were employed part-time or worked for small firms that pay low wages and do not offer health insurance as a fringe benefit. The Urban Institute study further noted that in 1979, the uninsured represented only 14 percent of the under 65 population. In 1982, during the 1981-1982 recession, this figure increased to 16 percent.

The Health Insurance Association of America (HIAA), in its testimony before the Subcommittee in April 1984 estimated that as of the end of 1982, 175

1/ As described in a paper presented at the First Annual Meeting of the Association for Health Services Researchers, June 11, 1984. These represent revisions in the estimates presented by Kathy Schwartz at the hearing held by the Subcommittee on Health of the Senate Finance Committee on April 27, 1984.

million persons or 87 percent of the under 65 civilian non-institutionalized population had one or more forms of private insurance coverage. This figure corresponds to the number with hospital expense protection, the most common form of private health insurance. Most of these persons also had coverage for other types of medical services, such as surgical expense protection (169 million) and major medical protection (160 million). The HIAA estimated that 27 million persons among the under-65, civilian, noninstitutionalized population were not covered under a private plan at the end of 1982. A number of these persons were, however, receiving assistance under various public programs such as Medicaid, the V.A., CHAMPUS, and Medicare. After correcting for enrollments in these programs, the number of persons without any private or public coverage was estimated to range between 10 and 15 million. These persons generally fall into two broad categories--those temporarily without coverage as they move in and out of insured status (such as the temporarily unemployed and children reaching the maximum eligibility age of dependent coverage) and persons who are likely to be without insurance for long time periods (e.g., the chronically unemployed or employed persons working for a firm that does not have a health benefits plan).

There is over a two-fold difference between the estimates of the size of the uninsured population presented by the Urban Institute researchers and HIAA, 32.7 million and 10 to 15 million respectively. In it's analysis of the Urban Institute figure, HIAA cited studies suggesting a 5 percent underreporting of health insurance coverage in household surveys, which could account for some of this difference. There are other factors (not cited by HIAA) which also might explain some of these differences, including whether people not continuously insured are counted as insured or uninsured, and how the HIAA figures are adjusted to account for people with duplicate coverage. After reviewing its own figure, the Urban Institute data and other published estimates, the HIAA suggested that the size of the uninsured population was probably in the range of 15 to 25 million persons.

B. Existing Federal Programs

The principal source of health care protection for the low-income nonaged population is the Federal/State Medicaid program. Medicaid provides medical assistance to specified categories of persons, i.e., the aged, blind, disabled and members of families with dependent children. In FY84, Medicaid recipients total an estimated 22.7 million. Aged recipients total 3.3 million, blind and disabled 2.9 million, adults in AFDC families 5.4 million, and children 11.1 million.

All States cover the "categorically needy" under their Medicaid programs. In general, these are persons receiving cash assistance under AFDC or SSI though some States impose more restrictive standards for their SSI populations. Thirty States (including D.C.) also extend coverage to the medically needy, i.e., persons whose income is slightly in excess of the standards for cash assistance but who: (a) are aged, blind, disabled, or members of families with dependent children; and (b) whose income (after deducting incurred medical expenses) falls below the State's medically needy standard. States are required to provide certain services, such as hospital care and physicians services, to the categorically needy. They may also include a broad range of additional services in their benefit packages. States may limit both the number of services offered and the extent of coverage within a service category (e.g., a limit on the number of days of hospital care). Thus the scope of services available to recipients and payments to providers is generous in some States and more limited in others.

Because of its linkage to the welfare cash assistance programs, only 38 percent of nonaged individuals with incomes below the poverty line were covered by Medicaid in 1982. Some of the remaining poor population have incomes slightly in excess of the State-established standards of need for AFDC (and therefore Medicaid). Further, persons not meeting welfare definitions (for example, singles, childless couples, and in some States, intact two-parent families) cannot receive Medicaid benefits regardless of their income.

A number of those poor persons not covered by Medicaid receive services under the auspices of other Federal and/or State programs. The Federal programs (which are described in the Appendix) generally authorize support for health programs geared toward specific target populations such as mothers and children, migrants, Indians, or persons in low-income areas.

III. PROVIDERS OF SERVICES

A. Ambulatory Care

Very little is known about the primary care services provided to the uninsured population in ambulatory settings. Data from the 1977 NMCES study suggest that the uninsured are less likely than insured populations to have a physician's office as their usual source of medical care (67 percent versus 84 percent, respectively) and are more likely to receive their care from a hospital outpatient department or a clinic. On the other hand, the fact that two-thirds of the uninsured do have a physician as their primary source of care runs counter to the stereotype that these individuals rely on public facilities or hospital outpatient departments for the bulk of their ambulatory care. Little information is available on how much physician care is unreimbursed, provided on a "charity" basis, or provided for a reduced fee.

In addition to the care provided in physicians' offices, there are a variety of public programs which sponsor primary care facilities. Federally sponsored providers include Community Health Centers ($337 million appropriated in FY 1984 supporting 590 centers), migrant health centers ($42 million appropriated in FY 1984 for 137 centers), and the Indian Health Service ($770 million appropriated in FY 1984). State, county and municipal governments also provide direct financial support for public clinics serving the poor and the uninsured. There is little information on the amount of this support which is available, or on how many persons are served.

Hospital outpatient departments provide a substantial amount of "charity" care on an ambulatory basis. Approximately one-quarter of all charity care provided by hospitals, over $400 million in 1982, was provided in hospital outpatient departments. 2/

Data from the 1977 NMCES study suggest that health insurance coverage affects the use of ambulatory care. People with health insurance averaged 3.4 physician visits per year compared to only 2.4 physician visits per year for the uninsured.

B. Inpatient Services

Hospitals provide a substantial amount of services to the poor and uninsured. Approximately 4.7 percent of hospital inpatient and outpatient services is uncompensated care. According to the American Hospital Association, community hospitals provided $6.2 billion of uncompensated care in 1982, representing the equivalant of nearly 16 million patient days. Of this amount, $1.7 billion was due to charity care and $4.5 billion was bad debts. Approximately 68 percent of the bad debts was due to care provided to uninsured patients. The remaining 32 percent of the bad debts was due to care provided to insured patients. The bad debts related to the care of insured patients are related in part to the patients' failure to meet their health insurance deductible and/or coinsurance obligations.

2/ Estimated using information presented in Hadley, J. and J. Feder, "Troubled hospitals: poor patients or management," Business and Health, September 1984, p. 15-19.

Little is known about the patients receiving uncompensated care in hospitals. One study suggests that most self-pay or charity patients (53 percent) are either maternity or accident cases. If patients with digestive disorders, mental disorders and complicated pregnancies are also included, these cases account for more than 70 percent of all self-pay or charity discharges. 3/ Uninsured populations do use fewer inpatient hospital services than insured groups. The 1977 NMCES data show that the uninusred use only 47 hospital days per 100 people per year while insured patients use 90 days per 100 people per year.

While all hospitals may provide some care to economically disadvantaged patients, public and private hospitals in urban areas provide more care to these individuals than other types of hospitals. This is in part because these hospitals also provide most of this country's hospital care. In 1982, hospitals in metropolitan areas provided 79 percent of all uncompensated hospital care and 76 percent of total hospital care. Forty-two percent of all uncompensated inpatient care was provided by hospitals in the 100 largest cities, split nearly equally between public and private hospitals. Public hospitals in both metropolitan and non-metropolitan areas provided two-fifths of the Nation's uncompensated hospital care but only one-fifth of all care.

There are some data which suggest that Medicaid coverage affects poor people's access to hospital care. While uncompensated care patients are equally distributed among public and private urban hospitals, the Medicaid cases are not. In urban areas, three out of four Medicaid patient days were in private hospitals, suggesting that insurance (i.e., Medicaid) can improve poor people's access to private hospitals.

3/ Sloan, F. A., J. Valvona and R. Mullner, "Identifying the issues: a statistical profile," presented at the conference on Uncompensated Hospital Care: Defining Rights and Assigning Responsibilities, Vanderbilt University, April 1984.

There is some evidence suggesting that teaching hospitals may provide a disproportionate share of uncompensated care. In 1982, teaching hospitals provided 36 percent of all uncompensated care while providing only 27 percent of all care, measured on the basis of charges. 4/

While urban hospitals may provide most of the hospital care for the economically disadvantaged, some rural hospitals also provide a substantial amount of care to the uninsured. In 1982, over 5 percent of the care in rural public hospitals and 4 percent of care in rural private hospitals was uncompensated. 5/

There is evidence suggesting that some hosptials providing large volumes of uncompensated care are in financial difficulty. However, the data suggest that the provision of a high volume of care to poor and uninsured patients is not the primary factor explaining the financial soundness of an institution. According to a recent study 6/, the principal factor contributing to financial stress is inadequate revenues. Lower revenues were attributed to differences in payer mix, namely lower percentages of commercially insured patients whose care is generally reimbursed on the basis of charges rather than costs. Thus, while financially stressed hosptials had the same incentives to shift costs as sound hospitals, they were less able to do so. There is evidence that financially stressed institutions have responsed to their financial pressures by reducing their free care patient load. This raises questions about the future access of the "uncovered" population to needed health services.

4/ Ibid.

5/ Ibid.

6/ Hadley, J. and J. Feder, p. 18.

IV. PAYMENTS FOR UNCOMPENSATED CARE

Hospitals may obtain financial support for the costs of uncompensated care from a variety of sources including State and local tax revenues and revenues from State-established uncompensated care pools. Many State statutes also hold counties legally liable for providing health care to indigents.

A. State and Local Programs

State and local governments sponsor a variety of programs supporting medical care to the economically disadvantaged. Existing programs can be classified into two major types--those that are targeted toward the provider and those that are targeted toward specific classes of individuals:

1. Programs targeted toward providers

a. Direct reimbursement through all-payer rate setting programs. Four States have mandatory hospital prospective payment systems which apply to all payers for hospital care in the State. Under these programs, the burden of uncompensated care costs is spread across all payers, both public and private. For example, Maryland hospitals are reimbursed for charity care and bad debts by having their approved rates include the lesser of the hospital's actual uncompensated care cost or the estimate of such costs made by the Maryland Health Services Cost Review Commission. In New Jersey, specific allowance for both charity care and bad debt costs is incorporated into each of the diagnosis-related group payment rates.

b. Revenue pools. Generally, this type of program, sometimes referred to as an uncompensated care pool, is designed as a mechanism for reimbursing hospitals for their uncompensated care. These programs may not involve the creation of new revenues, but simply redistribute existing resources to hospitals with high levels of uncompensated care. For example, in New York, hospitals pay a surcharge on revenues from third party payers (2 percent in 1983 increasing to 4 percent in 1985) which is collected in a pool. This pool is then redistributed to hosptials in proportion to their share of all uncompensated care. It was estimated that this pool reimbursed New York hospitals for 34 percent of their uncompensated care in 1983, increasing to 68 percent in 1985. Florida recently enacted a program under which an indigent care revenue pool is financed by assessing hospitals a fee of one percent on their annual net operating revenues.

c. Direct support of institutions such as public hospitals and clinics which provide care to the medically indigent.

2. Programs targeted toward individuals

a. State/county funded indigent care programs. These programs provide payments for services rendered to indigent persons not eligible for Medicaid, for example, single persons and childless couples. Covered services may be similar to those offered by Medicaid, though the scope of services is generally more limited. Funding is provided through State and/or county dollars.

b. Programs for certain population subgroups. Economically and/or medically disadvantaged populations which have been targeted for special assistance by some States include: the aged poor who have inadequate resources to meet the costs of prescription drugs (for example, the so-called pharmacy assistance programs in Pennsylvania, New Jersey and Maine), and persons with cystic fibrosis (Missouri).

c. Catastrophic health insurance programs. Several States (Alaska, Maine and Rhode Island) have programs for financing extremely high-cost medical care associated with catastrophic illness. While each State program is different, they all specify that the State is the payor of last resort after all available third-party coverage has been exhausted. They generally apply income and/or assets tests to determine eligibilty for payments. Further, certain cost sharing and/or deductible requirements are imposed.

d. Risk-Sharing pools. A number of States have developed insurance risk-sharing pools to provide access to insurance coverage for high risk individuals who would otherwise have trouble obtaining coverage. Minnesota, Indiana, North Dakota, Wisconsin, Florida, and Rhode Island have such pools. Connecticut also has a pool which is open to all residents, not just those which are considered high risk.

B. Legal Liability for Indigent Health Care

Many State statutes hold counties legally liable for providing health care to indigents. A recent survey 7/ shows that in nearly half of the States (48 percent), counties have sole legal responsibility for providing health care to indigents residing within their county. In 10 percent of the States, counties have discretion whether or not to assume full responsibility for providing indigent health care; in 8 percent of the States, the State and counties

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7/ National Association of Counties, "County Legal Liability for Indigent Health Care"; May 1984 (based on a survey response from 80 percent of the States).

share the responsibility; and in 10 percent of the States, counties have responsibility for certain programs or certain populations. (In an additional 5 percent of the States, counties have administrative functions though no funding responsibilities.) In 17 percent of the States, the State assumes all legal and financial responsibility for indigent health care costs, while in 5 percent of the States the responsibility is placed on municipalities.

It should be noted that the role of States and localities may change over time. Recently the State of California shifted all responsibility for the costs of the medically indigent non-Medicaid population to the counties.

V. ISSUES

Several questions can be raised about the provision of and payment for health care services to persons not having private insurance or public program coverage. Chief among these are: (1) the degree of access that the medically indigent have to needed health services; (2) the extent to which such care could be more appropriately rendered in less costly settings; and (3) the role of Federal, State and local governments, providers, employers, and private insurers in relation to this population group.

There is evidence that persons not covered under public or private programs use fewer hospital days and have fewer ambulatory visits than other population groups. These utilization patterns suggest that the uninsured may not have the access they need to medical care. In addition, there is some evidence that some providers currently rendering services to the uninsured may be restricting the amount of care they provide to this population. Some hospitals in financial difficulty are reducing the amount of free care they provide. Methods of rationing care may include discouraging hospital use by people unable to pay, transferring non-paying patients to public hospitals, and reducing the availability of services more heavily used by the uninsured poor (for example, restricting emergency room admissions). If these responses by providers become more prevalent, the access of the uninsured to hospital services could decline further. It is possible that the uninsured may be able to obtain more of their care from other providers. However, any consideration of the question of this population's access to services is hindered by the the fact that little is known about the amount of care rendered by providers other than hospitals.

The utilization patterns of the uninsured suggest that the care they receive is not being provided in a cost-effective manner. Some analysts have argued that the lower utilization of primary care services by the uninsured suggests that they may delay seeking care until it is unavoidable, thus losing the potential benefits of early detection and treatment. Also, some may rely upon higher cost hospital emergency rooms rather than outpatient departments, clinics, or individual practitioners for their primary care. Some public programs, such as the Community Health Center Program, do provide alternative, lower cost sources of primary care for the medically indigent. However, little is known about the adequacy of these programs for meeting the existing needs of this population. Some States are experimenting with so-called "case management programs" under Medicaid freedom-of-choice waivers. Under these programs, Medicaid beneficiaries choose a primary provider who then manages their care. The intention of these programs is that the "case managers" will assure that the patient will receive the care he or she needs, and that it will be provided in a cost-effective manner. However, it is not clear how the benefits of these programs could be extended to the uninsured.

Finally, there have been continuing discussions over the appropriate role of Federal, State and local governments, providers, employers and private insures in regard to this population. A number of proposals have been offered to restructure the Federal/State Medicaid program. These have taken a variety of forms including recommendations to severe the link between welfare and Medicaid thereby increasing the eligible low-income population, and/or to alter the existing balance between the Federal and State governments in financing health care for the poor. Some plans have called for the establishment of a federally-funded national program of basic health care benefits for low-income populations. Services not covered under the Federal plan could be covered by State programs with some Federal assistance. Alternatively, the primary responsibility for care to the poor could be transferred to the States with Federal assistance in the form of a block grant.

States have also been reassessing their responsibilities. This is reflected in recent modifications, both expansions and contractions, in their Medicaid programs. It is also evident in actions by some States with respect to the uninsured. These actions include establishment of uncompensated care pools and inclusion of uncompensated care costs under all-payer rate setting programs. States are also reassessing their role vis-a-vis the counties. For example, California recently transferred all responsibility for the cost of care of the non-Medicaid medically indigent to the counties. In about half the States, the counties have the sole legal responsibility for providing care to the indigent.

Private insurers and employers are trying to limit the cost of health care provided to employed populations. For example, some employers are demanding that their health insurance costs reflect only their own claims experience. Competitively negotiated contracts are also becoming more prevalent. These actions may limit the ability of hospitals to shift costs to recover the cost of their uncompensated care. Further, self-insuring employers exempt from State insurance regulations under the Employment Retirement Income Security Act, may not fully participate in State uncompensated care pools.

APPENDIX: Major Federal Health Programs for the Economically Disadvantaged

Medicaid

The Medicaid program, authorized under title XIX of the Social Security Act, is a Federal-State entitlement program that purchases medical care for certain low-income persons. Within Federal guidelines, each State designs and administers its own program.

All States must provide Medicaid services to the "categorically needy," which generally includes persons receiving assistance from the Aid to Families with Dependent Children (AFDC) program or the Federal Supplemental Security Income (SSI) program, for the aged, blind, and disabled. The Deficit Reduction Act of 1984, P.L. 98-369, requires States to extend Medicaid coverage to the following groups of persons meeting AFDC income and resources requirements: (a) first-time pregnant women from medical verification of pregnancy; (b) pregnant women in two-parent families where the principal breadwinner is unemployed, from the medical verification of pregnancy; and (c) children born on or after October 1, 1983, up to age 5 in two-parent families.

States are required to offer the following services to categorically needy recipients under their Medicaid program: inpatient and outpatient hospital services; laboratory and X-ray services; early and periodic screening, diagnosis, and treatment (EPSDT) for those under age 21; family planning services and supplies; physicians' services; skilled nursing facility (SNF) services for those over age 21; home health services for those entitled to SNF services; rural health clinic services; and certified nurse midwife services. States may offer a broad range of additional services such as prescription drugs and intermediate care facility services. States may limit the amount, duration and scope of the services they offer (e.g., 14 hospital days per year, three physician visits per month). In addition, the States may impose nominal cost-sharing with certain major exceptions, including charges for services to children under age 18, pregnancy-related services, and family planning services and supplies.

States may also cover the "medically needy," which includes persons who are aged, blind, disabled, or memebers of families with dependent children, and who are unable to afford medical care but whose incomes (after deducting incurred medical expenses) fall below the State's medically needy standard. States having medically needy programs must, at a minimum, provide ambulatory services for children and prenatal and delivery services for pregnant women.

The Federal Government is required to match whatever States spend for covered services to eligible persons. The Federal Govenment's share is based on a formula designed to provide a higher percentage of Federal matching to States with lower per capita incomes and a lower percentage of matching for States with higher per capita incomes. Federal matching for services varies from 50 to 78 percent. Total FY 1984 Medicaid costs are estimated to be $37.9 billion (Federal--$20.3 billion; States--$17.6 billion). In FY 1984, Medicaid is expected to provide services to an estimated 22.7 million persons, including 11.1 million children under age 21.

Maternal and Child Health Services Block Grant

The Maternal and Child Health (MCH) Services Block Grant, established by the "Omnibus Budget Reconciliation Act of 1981", (P.L. 97-35), and administered by the Public Health Service of the Department of Health and Human Services

(DHHS), supports health care services for mothers and children. Targeted towards those with low incomes or with limited access to health services, the program's aim is to reduce infant mortality and the incidence of preventable disease and handicapping conditions among children, and to increase the availability of prenatal, delivery, and postpartum care to low-income mothers.

Eligibility criteria are set by the States. States may charge for services provided; however, those mothers and children whose incomes fall below the poverty level may not be charged.

In FY 1984, 85 percent of the appropriation for the block is allotted among the States to be used for MCH and crippled children's and related services. The remaining 15 percent is reserved under a Federal set-aside for special projects of regional and national significance, research and training, and genetic disease and hemophilia programs.

In FY 1984, $399 million were appropriated for the MCH Block Grant. Since the implementation of the block grant in FY 1983, no data are available on the numbers of persons served by the program nationwide. In FY 1981, the title V MCH program which preceded the block grant helped to finance the provision of physician maternity services to 397,000 women, nursing maternity services to 522,000 women, and midwife services to 53,000 women. In addition, the program provided physician services to nearly 2.8 million children and nursing services to nearly 5.6 million children. The program in FY 1981 also financed inpatient services for 99,000 crippled children.

Health Care Services Provided by Hospitals Under the Hill-Burton "Free Care" Provision

The "Hospital Survey and Construction Act of 1946" as amended (title VI of the PHS Act) commonly known as the Hill-Burton Act, provided Federal assistance to construct, renovate and modernize hospitals and certain other medical facilities. Since 1946, the Hill-Burton program distributed about $4.4 billion in grants and $1.5 billion in loans and loan guarantees to roughly 7,000 facilities throughout the country. In return for such funding, the law required the hospital receiving the Federal assistance to make available a "reasonable volume of hospital services to persons unable to pay." This provision has become known as the Hill-Burton "free care" or "uncompensated care" provision. It was not until 1972, after a series of class action lawsuits on behalf of indigent persons seeking care, that the Department issued regulations to implement the "free care" provision.

Under the free-care obligation, a Hill-Burton facility must provide each year a certain amount of service, based on a formula, at no charge or at a reduced price of eligible persons. Generally, a hospital must meet the annual free care level each year for 20 years.

People whose incomes fall below the Federal poverty income guidelines are eligible for services at no charge at any Hill-Burton hospital with a free-care obligation. A hospital may also choose to provide free or reduced-cost care to people with incomes of up to twice these levels.

The Federal Government no longer makes funds available through the Hill-Burton program, but in 1984, the approximately 3,000 hospitals which are still under the free-care obligation are providing approximately $3 billion of free care to indigent individuals.

Community Health Centers

Section 330 of the Public Health Service Act authorizes grants to public and nonprofit entities to support the operation of community health centers

(CHCs) in low-income urban and rural communities or neighborhoods which have been designated by the PHS as medically underserved areas.

CHCs offer a range of primary health services on an ambulatory basis, including diagnostic, treatment, preventive, emergency, transportation, and preventive dental services. CHCs can arrange and pay for hospital and other supplemental services in certain circumstances.

In FY 1984, the CHC program received an appropriation of $337 million to support 590 community health centers which provide services to approximately 4.7 million medically underserved urban and rural residents.

Migrant Health Centers

Section 329 of the PHS Act authorizes grants to public and nonprofit private entities for the operation of health clinics providing primary health services for both migratory and resident seasonal farm workers living in communities which experience influxes of migrant workers.

The FY 1984 appropriation of $42 million is supporting the operation of 137 migrant health centers serving approximately 460,000 persons.

Appalachian Health Finish-Up Program

The Appalachian Health Finish-Up program is designed to make primary health care accessible, reduce infant mortality, and recruit health manpower in health manpower shortage areas in the Appalachian region.

The Appalachian Regional Commission, under the Appalachian Regional Development Act of 1965 as amended, awards project grants to support primary care facilities, hospital training courses, public education programs, and prenatal care services in rural Appalachian counties which have limited primary health care resources or an infant mortality rate one-and-a-half times the national average.

The Commission also works with the PHS to recruit and place National Health Service Corps and other primary care physicians in the region.

With the $5.2 million it is allocating to the Finish-Up program in FY 1984, the Appalachian Regional Commission expects to serve 204,000 persons through the primary care program and 9,900 persons through its infant mortality activities. Over the past three years the program has recruited 130 physicians to practice in the region.

Family Planning

Title X of the PHS Act authorizes support for family planning clinics and related activities. Most of the funding under title X is awarded to public or nonprofit private agencies to operate family planning clinics. These clinics offer such services as medical examinations, counseling, pregnancy tests, information and education activities, birth control, natural family planning, and infertility services. In FY 1984, the appropriation of $140 million for title X is being used to support directly approximately 4,500 clinics, as well as for related training and information and education activities. Approximately 3.7 million persons will receive family planning services under the program in FY 1984.

Childhood Immunization

Section 317(j) of the PHS act authorizes grants and related assistance to States and communities to establish and maintain immunization programs for the control of vaccine-preventable childhood diseases, such as polio, measles, tetanus, pertussis, rubella, and diphtheria.

The target population of the program is all children in the U.S. in the age groups of: (1) less than one year; (2) one year; and (3) five years who should be receiving immunizations against these diseases according to recommended medical practice. In FY 1984, there are approximately 11 million children in these age groups in the U.S., about half of whom will receive their immunizations through the public sector. In FY 1984, the $30.4 million appropriated for the childhood immunization program is being used in part to help pay for 25 million dosages of vaccine administered in the public sector.

Indian Health Service

The Indian Health Service (IHS) of the PHS, under the authority of the Snyder Act of 1921 and the Indian Health Care Improvement Act of 1976, P.L. 94-437, supports the provision of comprehensive health services to eligible Indians and Alaska Natives. Care is provided through project grants to tribes and tribal organizations, as well as through programs operated and managed directly by the IHS and tribes and tribal organizations under contract. Care is provided through hospitals, health centers, and smaller health stations and and satellite clinics.

In FY 1984, the IHS will spend an estimated $770.4 million to provide health services to approximately 931,000 Indians and Alaska Natives.

Alcohol, Drug Abuse, and Mental Health Services Block Grant

The Alcohol, Drug Abuse, and Mental Health Service Block Grant was established by the "Omnibus Budget Reconciliation Act of 1981," (P.L. 97-35). This block grant consolidates into a single authority of grants to States several Federal categorical programs for: (1) formula and project grants and contracts for alcohol abuse services; (2) formula and project grants and contracts for drug abuse services; and (3) grants for community mental health centers.

The FY 1984 appropriation for the Alcohol, Drug Abuse, and Mental Health Block grant is $462 million. No data is available on the numbers of persons served nationwide. However, States have reported a number of trends to the DHHS with respect to target populations under this block grant. According to the Department, States are giving priority to: (1) services for the chronically mentally ill; (2) services for opiate abusers, especially in States with a large urban population; (3) services in urban areas; (4) mental health services for certain special populations, such as the elderly, minorities, and children; and (5) the provision of direct rather than indirect clinical services to the seriously mentally ill.

Preventive Health and Health Services Block Grant

The Preventive Health and Health Services Block Grant was created by the "Omnibus Reconciliation Act of 1981," (P.L. 97-35), with the consolidation of eight categorical health programs into a single authority of grants to States. Under this block, States may use their allotments for purposes similar to the activities conducted under the categorical authorities included in the block, such as: (1) rodent control; (2) community- and school-based fluoridation programs; (3) hypertension control; (4) health education/risk reduction programs; (5) comprehensive public health services; (6) home health demonstration projects; (7) emergency medical services; and (8) rape prevention and services to rape victims.

Target populations for some of the programs under this block grant are:

Hypertension control--Indigent and/or medically underserved persons; minorities, employable males, the elderly, and rural populations;

Rodent control--Low- to middle-income urban communities, and densely populated communities;

Health-education/risk reduction programs--school-aged children, minorities, those at risk of chronic diseases, senior citizens, and adolescents.

The FY 1984 appropriation for the Preventive Health and Health Services Block Grant is $88.165 million. No data are available on the numbers of persons served by the program nationwide.

Medical Assistance to Refugees and Cuban/Haitian Entrants

The Refugee Act (P.L. 96-212) authorizes 100 percent federally funded medical assistance for eligible needy refugees during their first 3 years in the United States. Title V of the Refugee Education Assistance Act (P.L. 96-422), popularly referred to as the Fascell-Stone amendment, authorizes similar assistance for certain Cubans and Haitians who have recently entered the United Staes. The Federal refugee assistance program reimburses States 100 percent for the non-Federal share of Medicaid payments to refugees and entrants who qualify for that program. It also provides "refugee medical assistance" to needy refugees and entrants who are not categorically eligible for Medicaid. Medical assistance to refugees and entrants is authorized through FY 1984.

Medical benefits consist of payments made on behalf of needy refugees to doctors, hospitals, and pharmacists. Federal law requires State Medicaid programs to offer certain basic services, but authorizes States to determine the scope of services and reimbursement rates, except for hospital care.

In FY 1983, the Office of Refugee Resettlement of the Social Security Administration spent an estimated $135.8 million providing medical assistance for 95,000 refugees and Cuban/Haitian entrants.

Senator **Durenberger**. Good morning, everyone. The hearing will come to order.

A Senate colleague of mine in a recent speech advocated, as I have on numerous occasions in the past, the consumer choice approach for the American health care system, and during the question and answer period following his remarks one of the hospital administrators attending the session got up and said, "All right, if you want us to be competitive in the marketplace, that's fine. Just remember to be competitive. My institution isn't going to pay for the care of those who can't pay by upping the charges for those who can." And he went on to say that to make it in the so-called marketplace I was trying to help him design, that his institution would have to hold down its prices and not continue to cross-subsidize the poor. And he concluded by asking my colleague what will happen to the poor then? Well, my colleague had no easy answer. I'm sure he had an answer, but it wasn't satisfactory, and neither can I satisfactorily answer that question.

The cross-subsidization issue develops whenever price is not a factor in a purchasing decision. We have seen it in airlines and trucking and telephones, and a variety of areas, and it certainly does occur in most areas of public service delivery, where historically consumers have either been asked to or have been able to ignore price in choosing provider of service.

In a regulated system like we had in the telephone industry, long distance rates subsidized local service. I learned the other day from Alfred Kahn that in recent years the annual subsidy between long distance and local rates—that is, the amount of excess charges, if you will, in long distance rates that were being used to subsidize local rates—was $8 billion for the interstate long distance and $6 billion for the intrastate long distance. Now, this is no small amount, and the shift of these dollars back to local ratepayers will be hardfelt in the coming years. And it's going to happen.

Obviously, since the telephone has become a necessity, accommodations will have to be made to ensure access to phones for rural consumers, the elderly, the poor, and other groups that are at risk in our society. However, these accommodations in that area will be made explicitly, and they will no longer distort the incentives in the marketplace for telephone service.

As we create a price-sensitive health care marketplace, accommodations must also be made. These accommodations are necessary on moral as well as on economic grounds to assure access to quality services for all who need health care. We never want to return to a two-tiered system, with one standard of care for those who can pay and a second, substandard, for those who cannot.

This is our second hearing to examine the issue of health care for the economically disadvantaged. In the first hearing we focused on the issue of who are they. We learned that the population at risk are those who do not qualify for Medicare, Medicaid, or have sufficient insurance, and that includes more than 10 percent of all Americans. For this number, it appears that a significant proportion may be totally unsponsored in the financial sense.

Today we will learn more about these Americans, as we look at the issue of where they receive health care services and how the services they receive are provided and financed.

A third hearing will focus on the question of health maintenance for the economically disadvantaged, not just the issue of their sick care.

The current system has few incentives or programs for poor Americans to seek preventive health services. This hearing will examine existing facilities, and experimentation with disease prevention and health promotion for the unsponsored populations in our society. With the record of these three hearings we can move on to the next step—to identify policy options to resolve the health problems of the economically disavantaged.

We know there are no easy answers. I have learned this from my experience as the chairman of the Intergovernmental Relations Subcommittee. In that capacity I participated in the negotiations with President Reagan and State and local government officials concerning the federalization of Medicaid which took place in 1982. This experience leads me to the conclusion that the solution to the problem of the economically disadvantaged lies in a more explicit acknowledgement of the national responsibility for the care of the poor, and also for the need for a rearrangement for those current cash and in-kind income maintenance programs financed by all three levels of government.

Those of us who understand the problem and the opportunities in a more comprehensive approach will have to educate our colleagues in Congress and in the executive branch about it, and that a solution must be found through an explicit Federal policy. Without this recognition and commensurate action, I feel the market-oriented approach to health care reform may cause major social side effects that none of us want.

With that statement, I thank all of the witnesses who have agreed to join us this morning. I look forward to hearing the background that you will provide, and I am confident your testimony will help the process in which we are all now involved.

Our first two witnesses are Elmer Smith, Director of the Office of Eligibility Policy for the Bureau of Eligibility, Reimbursement, and Coverage at HCFA; and Dr. Robert Graham, Administrator, Health Resources and Services Administration, the Public Health Service, Department of Health and Human Services.

Welcome to you both. Elmer, you got announced first; you go first.

STATEMENT OF ELMER W. SMITH, DIRECTOR OF THE OFFICE OF ELIGIBILITY POLICY, BUREAU OF ELIGIBILITY, REIMBURSEMENT, AND COVERAGE OF THE HEALTH CARE FINANCING ADMINISTRATION

Mr. SMITH. Yes. Mr. Chairman, if I may, I'll file my statement for the record, and I'll speak to a few summary highlights.

Senator DURENBERGER. Both of your printed statements will be made part of the record.

Mr. SMITH. Fine. Thank you.

I think the first point is that the Medicaid Program is one of the major ways that economically disadvantaged persons get help with their health care expenditures. In 1983, 21.5 million persons received care under the auspices of the program, at an expenditure of

$33.3 billion in Federal/State funds. Of the recipients, 28 percent were related to the SSI Program, the aged, blind, and disabled, 66 percent were related to the AFDC Program—Aid to Families with Dependent Children, and 6 percent were other recipients. Two-thirds of the Medicaid recipients have income and resources below the poverty line, and these constitute 38 percent of those persons living in poverty. Using the poverty line as a reference point, the remainder of the recipients are basically near-poor, with their eligibility related to the income and resource standards of the cash assistance programs to which they are related, and thus they are still quite disadvantaged financially.

Overall Medicaid expenditures represent 10.5 percent of the personal care expenditures in the country at large.

Now, the second point is, since its inception—and I have been with the program since its inception—the Medicaid Program has never been, nor was it designed to be, a comprehensive program for all poor persons. The major groups of persons who are not covered by the program are, first, adults aged 22 to 64 who are either not disabled or are not parents of minor children; second, nondisabled parents in two-parent families who do not meet the AFDC test of unemployment; and, third, undocumented and certain other aliens.

Now, until the passage of the Deficit Reduction Act this year, no major changes have been made in mandatory eligibility groups in the Medicaid Program since 1973, and in that year Congress enacted the Supplemental Security Income Program. In addition to providing Federal cash benefits, it granted Medicaid eligibility to most people who received the Federal SSI payments. Even then, however, Congress allowed states to relate their eligibility conditions for the aged, blind, and disabled to their 1972 State plan requirements before SSI was enacted. Fourteen States have adopted this option which permits them to be more restrictive than the eligibility conditions applying to the Federal SSI Program.

The fact that there has been little effort to expand eligibility groups is in contrast to the changes that have been made over the years in the kinds of health services required to be offered by the States under the program. For example, among the mandatory services established since 1965 are the early periodic screening, diagnosis, and testing programs for children and family planning services.

There are four other aspects of the Medicaid Program I would like to highlight.

One feature seems to have been unintended in the original enactment of Medicaid, and that is its heavy involvement in long-term care. Currently, over 40 percent of the Medicaid expenditures are for skilled nursing and intermediate care facility services. And these expenditures in and of themselves represent almost 50 percent of the Nation's spending for these types of services.

Partly as a consequence of this and partly because of the health status of the individuals involved, almost three-quarters of the medicaid expenditures are made on behalf of aged, blind, and disabled persons; although, in terms of numbers of recipients, they represent less than a third of the recipients eligible under the Medicaid Program.

Related to something you spoke of earlier, Mr. Chairman, the Medicaid Program has moved, I think, far toward one of its original goals, which is bringing the poor into the mainstream of the provision of health care. We see, for example, that Medicaid recipients benefit on the average from the same number of physician visits as does the average insured person with the same health status. In other words, if you take people with insurance, and you place them in groups according to their health status—poor, excellent, and fair—you will find that Medicaid recipients when arrayed along those same lines will have the same number of physician visits.

In addition, under the EPSDT Program, over 2 million assessments are done each year to detect and identify health needs or disabling conditions of children.

In recent years, Congress has enacted certain provisions that extend Medicaid benefits to those who lose their eligibility as a result of earnings which disqualify them for payments under the cash programs. For example, some recipients, because of their earnings, will lose their AFDC eligibility or disabled recipients will lose their SSI disability. And there have been provisions in recent years which extend, for certain periods of time, the Medicaid benefits to those persons, even though they no longer qualify under the cash programs.

Finally, in my view the medically needy part of the Medicaid Program represents a type of catastrophic health financing program, since it allows people who have high medical expenses to spend down to levels to qualify for Medicaid support, provided they meet the other basic categorical requirements of being aged, blind, disabled, or in a family with dependent children. About 3.8 million people spend down in order to obtain Medicaid coverage.

That concludes my highlights, Mr. Chairman.

Senator **Durenberger**. All right.

Dr. Graham?

[Mr. Smith's written testimony follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

ELMER W. SMITH

DIRECTOR, OFFICE OF ELIGIBILITY POLICY
BUREAU OF ELIGIBILITY, REIMBURSEMENT AND COVERAGE
HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

FINANCE COMMITTEE

UNITED STATES SENATE

SEPTEMBER 28, 1984

I AM PLEASED TO HAVE THE OPPORTUNITY TO DESCRIBE FOR YOU MEDICAID'S COVERAGE OF HEALTH CARE FOR THE ECONOMICALLY DISADVANTAGED. DR. ROBERT GRAHAM, THE ADMINISTRATOR OF THE HEALTH RESOURES AND SERVICES ADMINISTRATION, WILL ADDRESS PUBLIC HEALTH SERVICE PROGRAMS IN THIS AREA.

AS YOU KNOW, MEDICAID IS A JOINT FEDERAL AND STATE FINANCIALLY SUPPORTED, STATE-ADMINISTERED ENTITLEMENT PROGRAM WHICH PAYS FOR THE HEALTH CARE FOR SPECIFIC CATEGORIES OF LOW-INCOME PEOPLE. FEDERAL LAW AND REGULATION MANDATE MEDICAID COVERAGE OF ALL AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) RECIPIENTS AND MOST SUPPLEMENTAL SECURITY INCOME (SSI), THE AGED, BLIND AND DISABLED, RECIPIENTS BUT GIVE STATES SOME FLEXIBILITY TO MOLD THEIR PROGRAMS TO SUIT STATE NEEDS. THE MEDICAID PROGRAM PROVIDES DIRECT VENDOR REIMBURSEMENT THROUGH STATE AGENCIES TO PUBLIC AND PRIVATE HEALTH CARE PROVIDERS. ALL FIFTY STATES AND THE DISTRICT OF COLUMBIA CURRENTLY HAVE MEDICAID PROGRAMS WHICH VARY SUBSTANTIALLY IN TERMS OF GROUPS OF RECIPIENTS SERVED, TYPES OF SERVICES COVERED AND COST OF THE PROGRAM. GUAM, PUERTO RICO, AMERICAN SAMOA, THE VIRGIN ISLANDS AND THE NORTHERN MARIANAS ALSO HAVE MEDICAID PROGRAMS.

ELIGIBILITY

THE MEDICAID PROGRAM EMPLOYS A BASIC LEVEL OF ELIGIBILITY ACROSS ALL STATES AND PERMITS THE STATES TO MODIFY THAT LEVEL WITHIN CERTAIN CONSTRAINTS AND STILL RECEIVE FEDERAL MATCHING FUNDS. EACH STATE INDICATES THE PARAMETERS OF ITS PROGRAM IN A PLAN

SUBMITTED TO AND APPROVED BY HCFA. EVERY MEDICAID PROGRAM MUST PROVIDE COVERAGE TO ALL PERSONS RECEIVING CASH ASSISTANCE IN THE AFDC PROGRAM. THIS REQUIREMENT INCLUDES THOSE STATES WHICH HAVE CHOSEN TO COVER TWO-PARENT FAMILIES IN WHICH THE PRINCIPAL WAGE EARNER IS UNEMPLOYED AND THE FAMILY IS RECEIVING AFDC CASH PAYMENTS. MEDICAID ALSO COVERS MOST PERSONS ELIGIBLE FOR THE SSI PROGRAM. STATES MUST ALSO COVER PEOPLE WHO LOST SSI DUE TO SOCIAL SECURITY COST-OF-LIVING ADJUSTMENTS (COLAS) WHO WOULD CONTINUE TO QUALIFY BUT FOR COLAS. AS A RESULT OF THE DEFICIT REDUCTION ACT OF 1984 (P.L. 98-369), STATES MUST NOW ALSO COVER THREE OTHER GROUPS NOT RECEIVING CASH:

- POOR CHILDREN UP TO AGE FIVE (PHASED IN BETWEEN NOW AND 1989) REGARDLESS OF FAMILY STRUCTURE;

- PREGNANT WOMEN WHO ARE POOR AND WOULD BE ELIGIBLE FOR AFDC IF THE CHILD WERE BORN; AND

- PREGNANT WOMEN IN TWO-PARENT FAMILIES WHERE THE PRINCIPAL WAGE EARNER IS UNEMPLOYED.

ADDITIONALLY, STATES HAVE A NUMBER OF OPTIONS TO COVER FAMILIES OR CHILDREN WHO ARE POOR ENOUGH TO QUALIFY FOR AN AFDC CASH PAYMENT BUT DO NOT RECEIVE IT FOR SOME REASON. THE MOST IMPORTANT OF THESE ARE THE "RIBICOFF CHILDREN" -- CHILDREN WHO FAIL TO MEET THE AFDC DEFINITION OF "DEPENDENT" BECAUSE, FOR

EXAMPLE, THEY LIVE WITH BOTH PARENTS, NEITHER OF WHOM IS DISABLED. ALL STATES COVER AT LEAST LIMITED SUBGROUPS AND 24 STATES COVER ALL SUCH CHILDREN.

OTHER GROUPS THAT MAY BE COVERED AT THE OPTION OF THE STATES ARE PERSONS FOR WHOM STATES ARE MAKING ADDITIONAL CASH PAYMENTS SUPPLEMENTING THE BASIC SSI PAYMENT LEVEL EITHER ACROSS THE BOARD OR JUST WHEN SPECIAL NEEDS HAVE BEEN IDENTIFIED. SUBJECT TO CERTAIN FEDERAL REQUIREMENTS, THEY MAY ALSO PROVIDE MEDICAID TO INSTITUTIONALIZED PERSONS NOT RECEIVING A STATE OR FEDERAL SSI PAYMENT BUT WHO WOULD BE ELIGIBLE IF THEY LIVED IN THE COMMUNITY. THIRTY-EIGHT STATES PROVIDE SUCH PAYMENTS AND MEDICAID TO SOME GROUPS OF AGED, BLIND AND DISABLED.

STATES ALSO CAN USE HIGHER INCOME ELIGIBILITY LEVELS FOR PEOPLE IN INSTITUTIONS (OF UP TO 300 PERCENT OF THE SSI LEVEL, NOW 3 X \$314 = \$942 MONTH). TWENTY-SEVEN STATES USE THIS OPTION, INCLUDING ALL STATES WITHOUT A SPEND-DOWN PROGRAM.

STATES MAY, AT THEIR OPTION, ALSO COVER INDIVIDUALS WHO, IF THEY HAD LESS INCOME, WOULD QUALIFY IN THEIR STATE IN ONE OF THE ELIGIBILITY GROUPS LISTED ABOVE. THIRTY STATES COVER THIS "MEDICALLY NEEDY" POPULATION. THE SAME INCOME AND RESOURCE LEVELS MUST BE USED FOR ALL MEDICALLY NEEDY INDIVIDUALS IN A STATE. INCOME LEVELS MAY NOT EXCEED 133 1/3 PERCENT OF THE AFDC PAYMENT LEVEL FOR A FAMILY OF THE SAME SIZE. INDIVIDUALS AND FAMILIES OVER THIS CEILING MUST "SPEND-DOWN" EXCESS INCOME ON MEDICAL SERVICES BEFORE BECOMING ELIGIBLE FOR MEDICAID.

GROUPS NOT COVERED

BY LAW, MEDICAID CAN ONLY BE PROVIDED TO GROUPS LISTED IN TITLE XIX OF THE SOCIAL SECURITY ACT. ANYONE NOT FITTING THOSE CATEGORIES IS INELIGIBLE FOR MEDICAID, NO MATTER HOW POOR OR SICK, EVEN IN STATES COVERING THE MEDICALLY NEEDY.

THE LARGEST INELIGIBLE GROUPS ARE:

-- ADULTS AGED 21-64 WHO ARE NOT DISABLED OR PARENTS OF MINOR CHILDREN.

-- NON-DISABLED PARENTS IN TWO-PARENT FAMILIES WHO DO NOT MEET THE AFDC DEFINITION OF "UNEMPLOYED."

-- UNDOCUMENTED AND CERTAIN OTHER ALIENS.

RECIPIENTS

IN 1983, NEARLY 21.5 MILLION PERSONS RECEIVED MEDICAID-FINANCED SERVICES -- ABOUT 66 PERCENT WERE IN AFDC-TYPE FAMILIES; 28 PERCENT WERE AGED, BLIND OR DISABLED; AND THE REMAINING 6 PERCENT WERE OTHER TITLE XIX RECIPIENTS.

MOST MEDICAID RECIPIENTS ARE VERY POOR -- OVER TWO-THIRDS HAVE INCOME OR RESOURCES BELOW THE POVERTY LINE. THE OTHER THIRD ARE STILL QUITE DISADVANTAGED FINANCIALLY. AS I NOTED EARLIER, MEDICAID ELIGIBILITY IS TIED TO THE RULES AND STANDARDS SET FOR THE CASH ASSISTANCE PROGRAMS. THESE STANDARDS VARY WIDELY FROM STATE TO STATE FOR AFDC BUT CONTAIN A CERTAIN DEGREE OF NATIONAL UNIFORMITY FOR SSI. THE AFDC MONTHLY PAYMENT STANDARD OR MEDICALLY NEEDY INCOME LEVEL FOR A FAMILY OF 4 RANGES FROM $140 IN TEXAS TO $801 IN CALIFORNIA.

BECAUSE OF THE WIDE STATE VARIATIONS IN INCOME CUTOFFS, COUPLED WITH THE CATEGORICAL NATURE OF THE PROGRAM, SOME VERY POOR PERSONS ARE NOT COVERED BY MEDICAID. ABOUT 38 PERCENT OF ALL PERSONS BELOW THE POVERTY LINE ARE MEDICAID RECIPIENTS. ROUGHLY HALF OF ALL PERSONS BELOW THE POVERTY LINE DO NOT FIT THE CATEGORICAL PROGRAM REQUIREMENTS AND WOULD NOT BE ELIGIBLE FOR MEDICAID REGARDLESS OF A STATE'S INCOME CUTOFF.

SERVICES

THE SCOPE OF COVERED SERVICES VARIES CONSIDERABLY FROM STATE TO STATE. ALL STATES MUST COVER CERTAIN MANDATORY SERVICES FOR THE CATEGORICALLY NEEDY AND, FOR ALL PRACTICAL PURPOSES, FOR THE MEDICALLY NEEDY. STATES ALSO HAVE THE OPTION TO PROVIDE A WIDE RANGE OF OTHER SERVICES.

- STATES MUST OFFER THE FOLLOWING MANDATORY SERVICES TO ALL CATEGORICALLY NEEDY RECIPIENTS: INPATIENT HOSPITAL SERVICES, OUTPATIENT HOSPITAL SERVICES, RURAL HEALTH CLINIC SERVICES, OTHER LABORATORY AND RADIOLOGY SERVICES, SKILLED

NURSING FACILITY (SNF) SERVICES AND HOME HEALTH SERVICES FOR INDIVIDUALS AGED 21 AND OVER, EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT FOR CHILDREN (EPSDT), FAMILY PLANNING SERVICES AND SUPPLIES, NURSE-MIDWIFE SERVICES (IF MIDWIVES ARE LICENSED IN THE STATE) AND PHYSICIAN SERVICES. THIS COVERAGE HAS MEANT, FOR EXAMPLE, THAT OVER 2 MILLION EPSDT ASSESSMENTS ARE PROVIDED A YEAR AND THAT THE AVERAGE MEDICAID RECIPIENT NOW RECEIVES THE SAME NUMBER OF PHYSICIAN VISITS AS THE AVERAGE INSURED PERSON WITH THE SAME HEALTH STATUS.

o STATES MAY ALSO PROVIDE ADDITIONAL SERVICES SPECIFIED IN THE FEDERAL REGULATIONS. SHOULD THEY CHOOSE TO OFFER AN OPTIONAL SERVICE THEY MUST OFFER THE SAME SERVICE, WITH THE SAME UTILIZATION LIMITS AND THE SAME COPAYMENTS, IF ANY, TO EACH OF THE CATEGORICALLY NEEDY GROUPS. FOLLOWING PASSAGE OF THE OMNIBUS BUDGET RECONCILIATION ACT IN 1981 (P.L. 97-35), HOWEVER, STATES WERE GIVEN THE FLEXIBILITY TO VARY THE BENEFIT PACKAGE AMONG THE DIFFERENT MEDICALLY NEEDY GROUPS. THE MOST POPULAR ADDITIONAL SERVICES OFFERED INCLUDE: CLINIC SERVICES, PRESCRIPTION DRUGS, INTERMEDIATE CARE FACILITIES (ICFS) AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED.* OTHER OPTIONAL SERVICES INCLUDE DENTAL SERVICES, EYEGLASSES, PHYSICAL THERAPY AND PROSTHETIC DEVICES. NEARLY HALF THE STATES OFFER 20 OR MORE ADDITIONAL SERVICES. THE MOST GENEROUS PROGRAMS TEND TO BE LOCATED IN LARGE STATES WITH LARGE NUMBERS OF MEDICAID RECIPIENTS. FOR EXAMPLE, CALIFORNIA WHICH OFFERS 30 OUT OF 31 ADDITIONAL SERVICES alone has 16 percent of all Medicaid recipients. New York which offers 28 additional services has 10 percent of all Medicaid recipients. Through home and community-based waivers, States can also provide a wide array of noninstitutional long term care services, such as personal care services, not otherwise offered.

Expenditures

Medicaid spending for health care for the poor is substantial. In Fiscal Year 1983, Medicaid spent 33.3 billion Federal and State dollars, representing about 11 percent of the nation's total personal health care spending.

Nearly three-fourths of Medicaid spending is for the most vulnerable of the sick, poor population -- the old and disabled (SSI). Much of this is for long term care. About 43 percent of Medicaid outlays were spent for SNF and ICF services. Many of the Medicaid recipients in long term care institutions started out above the Medicaid income standard and, lacking private insurance, spent down to the Medicaid level. About 7 million persons each year were originally above the poverty line and either spent down to Medicaid or met the higher income standards many States have for institutional care. Because there are few private insurance options for long term institutional care, Medicaid alone

CONTRIBUTES ALMOST HALF THE NATION'S SPENDING FOR THESE SERVICES. PRIVATE HEALTH INSURANCE CONTRIBUTES LESS THAN 1 PERCENT TOWARD FUNDING OF SUCH CARE.

CONCLUSION

IN SUMMARY, THE MEDICAID PROGRAM IS BY LAW TIED TO THE CASH ASSISTANCE PROGRAMS. NO MATTER HOW POOR A PERSON IS, HE OR SHE MUST FIT INTO ONE OF THE PRESCRIBED CATEGORIES TO BE ELIGIBLE FOR THE PROGRAM. WITHIN THOSE CATEGORIES, STATES HAVE A GREAT DEAL OF LATITUDE IN SETTING THE INCOME AND RESOURCE LIMITS THAT DETERMINE ELIGIBILITY. IN 1983, ABOUT 21.5 MILLION PERSONS RECEIVED SERVICES. SIMILARLY, BEYOND A PRESCRIBED SET OF SERVICES, STATES HAVE A GREAT DEAL OF LATITUDE TO DETERMINE WHICH BENEFITS TO OFFER. IN 1983, PAYMENTS TOTALED $33.3 BILLION.

IT IS CLEAR THAT THE MEDICAID PROGRAM MAKES A SUBSTANTIAL CONTRIBUTION TOWARD THE FINANCING OF HEALTH CARE SERVICES FOR THE ECONOMICALLY DISADVANTAGED.

STATEMENT OF ROBERT GRAHAM, M.D., ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. **Graham.** Mr. Chairman, I would like to highlight the information in our prepared statement. The responsibility of the Public Health Service and our agency is essentially to work in partnership with community institutions and State and local governments to provide increased access to individuals who would not otherwise have access to health services.

Recognizing that the organization and financing for health services are undergoing very rapid changes, it becomes increasingly difficult to assure that individuals do have some assurance of access to health services.

Historically—and by that I take the long view of some 75 to 100 years—the major responsibility for assistance to individuals who did not have access to or who did not have financial resources for medical care has been at the local level—State, city, and county programs. Indigents also were aided by philanthropic individuals and groups.

During the last 20 to 30 years, Federal programs have been enacted to assist local entities in helping these individuals receive care. Our present strategy is to continue to work closely with public and private entities who share our mission of trying to improve access.

We do that through a system of block grants and categorical grants and manpower training programs.

We administer the community health centers program. At the present time there are somewhat over 600 federally funded community health centers. In addition, there are approximately 200 health centers that were formerly federally funded, whose major mission is to provide services to individuals who might otherwise be termed medically indigent.

The community health centers are trying to establish a viable financial base. The purpose of the Federal supplementation of their operational revenues is to assure that services are available to individuals who may otherwise be unable to pay anything or unable to pay the full cost of the services.

We administer the National Health Service Corps, which has well over 3,000 health professionals assigned throughout the United States. Some of those assignments are in remote geographic areas where access barriers can be both financial and geographic. Many are assigned in urban and inner city areas in conjunction with a community health center program in an effort to augment the financial resources available to those centers to deliver services.

The maternal and child health block grant is providing funds to States to allow them to supplement their primary care with services specifically oriented to mothers and infants.

Our primary care training program strategy—the training of family physicians, primary care internists and pediatricians, nurse practitioners and physician assistants, and support of area health education centers—has been an effort to produce a type of health professional who can address the specific needs of access to health services. It has been demonstrated that one of the barriers to access is not having the right type of practitioner available in the right place at the right time. As we produce more of these primary care practitioners, we find that they are establishing practices both in rural and inner city areas and expanding access to services.

We also continue to have the responsibility for monitoring the Hill-Burton free care assurance. Hospitals nursing homes that received grant or loan support from the Federal Government to construct or renovate facilities have an obligation to provide a certain proportion of their operating revenues for uncompensated services. It is our responsibility to make sure that those institutions are carrying out their assurances over the 20-year period as required by the law.

This brief review shows, the strategy we are following in concert with the State and local institutions. We have tried to develop an infrastructure so that as our system goes through the changes we do not find ourselves disenfranchising large numbers of our citizens from access to services.

We do not view this as a solely Federal responsibility but as a shared public responsibility with other entities. We are working very closely through these programs and with the other State and local entities to bring this about. I think that we have some measurable gains and accomplishments to point to. We are very well aware of the challenges which still await us.

Thank you.

Senator DURENBERGER. Thank you very much.

[Dr. Graham's written statement follows:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

BY

ADMINISTRATOR

HEALTH RESOURCES AND SERVICES ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

SENATE FINANCE COMMITTEE

SEPTEMBER 28, 1984

Mr. Chairman,

I am Dr. Robert Graham, Administrator of the Health Resources and Services Administration (HRSA), an agency of the U.S. Public Health Service. It is with great pleasure that I appear before you today to discuss the delivery of health care to the individuals of this Nation who are economically disadvantaged.

The structure of our health care financing arrangements is not one that adapts easily to the stresses of changing unemployment, welfare policies, cost containment measures, and shifting institutional priorities. As a result, that group of Americans for whom such inexact terms as "medically underserved" or "medically indigent" were invented, is a moving target for any public or private policies directed at these problems.

As this nation continues its efforts to grapple with the overall problem of health costs and the perverse incentives that have led to these rising costs, there remains a portion of our population who yet face serious barriers to adequate care. While Medicare and Medicaid have accomplished much, there has continued to be the need for a constellation of programs that target resources to population groups who for a variety of reasons in addition to lack of adequate coverage are medically disadvantaged.

Our programs are ones that both supplement and complement the roles of Federal financing programs, the activities of State and local government, and the private sector to make certain that no American is denied needed medical services. We accomplish this mission by delivering personal health services directly to Federal beneficiaries--American Indian, Alaskan Natives, Hansen's Disease patients--and by helping communities address the problems of those unable to pay or gain access to providers.

Assistance to communities takes many forms including:

- grants to community and migrant health centers so they can serve the disadvantaged and yet maintain a firm financial footing while providing quality primary care services;
- providing National Health Service Corps members to manpower shortage areas;
- offering support to states and academic institutions through categorical programs designed to prepare health professionals to function more effectively in ambulatory and community-based settings.

- ensuring that hospitals constructed with Federal funds provide a reasonable volume of uncompensated care in their localities;

- providing block grants to states to help them care for mothers and children, and particularly crippled children.

And the strategies appear to be working.

MCH

The Maternal and Child Health Services (MCH) Block Grant, which was created in 1981, consolidated seven existing categorical programs into one block. It allows each State to develop its own programs and set its own priorities. States carry out a wide variety of activities -- Maternal and Infant Care Programs, Adolescent Health Programs and Outreach, Crippled Children Identification and Treatment, School Health, Immunization, Nutrition -- especially WIC Program Coordination and Programs to serve Chronically Ill Infants and Children.

Primary Care Providers

Continued expansion of the supply of primary care physicians and the resulting changes in their geographic distribution can be expected to help alleviate much of the Nation's medical service needs over the next decade. Existing programs of financial aid for primary care physician training include the family medicine training program, the program of aid to family medicine departments, and the general internal medicine and general pediatric training program. Working in conjunction with academic institutions and community health facilities, the Federal government also supports training of physician assistants and nurse practitioners to provide primary care services.

Community Health Center Programs

As a result of the Community Health Center programs working with States and medical societies, and serving only high need areas, much closer cooperation has been achieved with the private medical community. There are memoranda of agreement with 40 States which provide for Federal/State cooperation in administering the CHC program and other primary care programs. Each year, the Governors are invited to comment on each Federal CHC funding decision. Each CHC applicant is required to seek comments from their local or State medical society. In addition, Governors, State Health Departments and State Medical Societies have been contacted for their views on centers' operations within their States, and a majority of States have been party to discussions with respect to their extensive involvement in project monitoring and administration during Fiscal Years 1982 and 1983.

Special Health Care Needs

With the Nation's elderly population continuing to grow, we are mandated to re-examine the concerns of this group and this has focused greater attention on the Home Health Services and Training Program. This effort makes available grants to public and private nonprofit entities to meet the initial costs of establishing and operating home health programs, and for loans to proprietary entities for these purposes.

It is our intention to give preference to those applicants which intend to provide services in areas where there is a high percentage of the population composed of individuals who are elderly (persons over 65 years of age), medically indigent or disabled.

National Health Service Corps

Our studies also show that, despite the increasing numbers of physicians and other health care providers, there will be certain geographic areas which will probably never be served through private sector efforts because of the areas' low income and economically depressed situation. The NHSC is developing an approach which would result in a future program of a small nucleus of obligated federally paid physicians and other health care providers who would be assigned to serve these areas.

Mr. Chairman, I would like to stress again that the examples I have given illustrate HRSA's role, not as the nation's provider of last resort, but the agent of the Federal government which helps local public and private entities serve the function of guarantor of access to services.

In the last few years, great strides have been made in the distribution of health professions and the placement of facilities. While continuing to work on these problems, we are now focusing as well on the access problem in terms of special population groups with particular disease patterns and service needs. Together with our partners -- states, localities, and the private sector -- we can make a difference on the ultimate goal -- improved health status.

Senator DURENBERGER. Mr. Smith, I wonder if you would give us some sense of your view of if we could start over again what it might look like. You did make the point near the end of your oral statement what I know has bothered me a great deal, and that is the point about the elderly in effect spending down to qualify for Medicaid. And I have always wondered why it is that in the Medicaid Program, for example, we treat the aged, blind, and disabled, and everyone else, in effect, in the same program. But particularly with regard to the aged, is there a good reason other than income limits why the aged poor should not be, from a programmatic standpoint, be financed from a different program, say from Medicare, as opposed to the rest of those who are all below a certain income level?

Mr. SMITH. Well, the Medicare Program, of course, Mr. Chairman, is related to insured status under the social insurance system, the retirement, survivors, and disability programs, and it is of course based on work history and earnings credits.

About 3.3 million Medicaid recipients are also receiving Medicare, but their incomes are so low that they can still qualify through the SSI Program or otherwise for Medicaid.

The Medicaid Program, of course, was designed to provide assistance from general revenues for those people whose income was so low that they needed particular assistance with their medical expenses. One of the tests of that has been, if they qualify for the cash assistance programs like the Supplementary Security Income Program, then it is assumed, and the Medicaid title is written that if you receive a cash payment under the SSI Program you are automatically eligible under the Medicaid Program. Now, that works everywhere except in those 14 States that have decided to retain some of the more restrictive provisions that they had under their 1972 State plans.

But I think the basic thing we are talking about is, the one program, Medicare, is related to trust fund payments where people have work histories and their eligibility is related to their eligibility under title II. Under the other program Medicaid, we are talking about people who either have an insufficient work history or incomes too low from that source and they need some supplementation.

Senator DURENBERGER. Would you describe for us generally how the 3.8 million spend down to Medicaid?

Mr. SMITH. Under the program, States have a choice of a so-called budget period. They can choose a month to look at or they can choose up to 6 months to look at. And for that period of time they look at the question of both the income of the individual as well as the question of what their medical expenses are. Now, for people who are in institutions, those expenses are so relatively stable that we allow a projection, we allow States to look ahead and estimate what those expenses are going to be. For people who are not in institutions, when they come and apply, if they do not have accrued medical bills which will essentially match the difference between the so-called medically needy income level which every State establishes and whatever income they have, then the State waits until they actually do accrue those bills. They do not have to be paid bills; a person does not have to pay them; they just have to accrue them.

Once that is done and they match the excess, then expenditures from that period of time for their health care services are provided by the Medicaid Program until the end of the budget period. Then this step is done all over again, a redetermination is done all over again, for the new budget period. Usually, unless there is some evidence of some change in circumstances, like acquiring more resources, the individual's eligibility continues during the next budget period.

Senator DURENBERGER. Can you give us some idea of the kind of changes that States are making in their Medicaid plans currently? How might they be using the 2176 and 2175 waivers to expand the number of persons eligible?

Mr. SMITH. States have been quite active in using 2175 and 2176 both. There are about 23 States, I believe, that have freedom of choice 2175 waivers, and there are a somewhat larger number of States that have applied for home and community-based service waivers.

Now, under the freedom of choice waivers, they do not act to expand eligibility at all; they only apply to people who are already eligible. What they do permit the State to do is to find more cost-effective ways of providing the care. One way is by establishing an entity to be a case manager—a physician or an HMO or some other entity to be a case manager—and to be the point of referral of the individual recipient to the various kinds of health services they need. Another way is by allowing the State essentially to go out and seek, through a competitive bidding process or a negotiation process, providers who will agree to meet all the quality standards and all of the access standards of the State, but who will agree to provide the care at a lesser cost. If that is done and there are a sufficient number of providers available to provide access, the State can then restrict the individual recipient to receiving services from that individual.

It is a little trickier under the home and community based waivers, because then you are making a determination of people who would be institutionalized, and you are trying to provide them care in the community. Now, in a sense you are not expanding eligibility, because you are trying to make that determination; but I think, in essence, probably some people are getting covered who otherwise would not get coverage under the Medicaid Program.

In addition, you are permitted to provide certain services under the home and community based waivers that are not a part of the ongoing title XIX State plan—I might mention respite services, for example, that are not generally provided as a part of the title XIX State plan.

Senator DURENBERGER. But as you watch this process, are the States starting to come back now with some recommendation, either on the expansion of coverage or on the expansion of eligibility, or on some other related issue, now that they are starting to achieve some of the goals that some of those waivers were designed to help them achieve?

Mr. **Smith**. I can speak specifically to the freedom of choice waivers, because they come under my jurisdiction in the Health Care Financing Administration.

As you may recall, we are required to submit a report to the Congress, making recommendations. This report will be submitted this fall on the freedom of choice waivers, and will indicate both what has been done and some recommendations for changes in that authority.

Meanwhile, in addition, Congress enacted the so-called moratorium in the Deficit Reduction Act, and that moratorium said that if States decide to expand their eligibility criteria, if they decide they will adopt different income standards than those that apply in the cash programs and are more liberal, they will be permitted to do so for a 30-month period. In addition, Congress asked for a report in this area and asked us to look specifically at the interface between the cash assistance income and resource standards and those applied to the Medicaid Non-cash Program, and to make recommendations as to whether we should stay closely linked with those cash assistance programs or whether we should depart. We are in the very early stages, since this authority was only enacted about 2 months ago, of contacting the States and working with them to get their views on this subject. We are using at the moment what is called the "Eligibility Technical Assistance Group" of the State medicaid directors to canvass the States.

Senator **Durenberger**. Dr. Graham, you trace for us in your oral statement the transition from the local responsibility for the economically disadvantaged to some combination of Federal, State, and local. And then, having described specifically the Federal entities involved—the Community Health Center Program, the National Health Service Corps, Primary Care Training Programs, Hill-Burton, MCH—let me ask you if, as you look at it today, you can summarize for us what it is the Federal Government is trying to do to facilitate the delivery of local services to the economically disadvantaged? And I don't mean to ask you to go down each of the programs and repeat it; but why, for example, is it necessary to have Federal money going into primary care training programs, other than the fact that it's one quick way to get it done and some Senator or some Congressman started this off as a program?

I'm trying to get out of you, I guess, what you sense of the current glue that holds the Federal appropriations in this area together.

Dr. **Graham**. There are probably some dangers of over-simplification in trying to characterize the Federal philosophy in one or two terms. I think a fair characterization would be that our present strategy is trying to put resources at the disposal of local public and community groups to provide for increased access to services. And certainly the block grant approach is very clearly of that philosophy in trying to use Federal tax revenues but to leave the decision for their expenditure not in Federal hands but in State or local hands under general Federal guidelines.

This is the strategy that we are embarked upon with the National Health Service Corps and community health centers. We have more than 45 memoranda of agreement with State health departments for community health centers and about 35 for the National

Health Service Corps. These agreements make us partners in planning with State officials as to how those resources are to be expended and what the priorities are for expenditure. Just as there are Federal expenditures for activities in this area, there are considerable local expenditures, and we are trying to make sure that those are together.

Our primary care training strategy, on which I will elaborate when I will see you again Monday morning when we will be talking specifically about graduate medical education, is to assure that there will be sufficient primary care providers, particularly physicians, to serve as the front line of care providers. In the late sixties training for the general practice of medicine was almost disappearing in medical schools, and that appeared to create a vacuum in the system. We are trying to assist in making sure that those types of physicians and other primary care providers are trained.

For every dollar of Federal money spent on family practice, $10 of State money was spent over the last two decades.

Senator **Durenberger**. I guess the next step in the question is not so much a motivation but a timing question. You are still running a Hill-Burton Free Care Program, and it strikes me that the rationale behind the Hill-Burton Program was not to provide health care for those who couldn't provide for it themselves; it wasn't a Medicaid building program in its entirety; it was in large part an effort to provide access generally to people in parts of the country that were presumed to lack access or even in rural areas. It was sort of the REA, if you will, of its time. And it was premised on a variety of notions in which access had some mileage definition and some doctor definition.

But today we don't run Hill-Burton anymore—I mean, we aren't building anymore Hill-Burton Programs. And one of these days you can bail out of the free-care business via Hill-Burton, can you not? I mean, at some point there is no obligation?

Dr. **Graham**. At some point the provisions in the statute will run out, that is correct.

Senator **Durenberger**. At what point can you predict that the National Government will not have to be in the Primary Care Training Program? I mean, are we getting close to that? Or do you want to wait and talk about that on Monday morning?

Dr. **Graham**. I think we ought to talk about it more substantively on Monday morning. That point is a moving target which depends upon some other actions that are taken related to support for graduate education and upon what happens in medical education.

Senator **Durenberger**. But if we did a good job of meeting the needs in graduate medical education generally, we might not have to run a Primary Care Training Program because we have sort of been successful—have we not?

Dr. **Graham**. Sure. History shows that the Federal sector or the public sector, again at the State level, has been involved to address what appear to be imbalances in the system and that when those imbalances appear to have been straightened, there is no compelling reason to continue to spend tax revenues.

Senator Durenberger. Then, in that context, where would we find the Community Health Centers Program and our Federal involvement there?

Dr. Graham. This is probably a more complicated question. The community health centers are specifically located in medically underserved areas. They are located in areas with the greatest need for access to services to individuals or communities that might not otherwise get it.

I don't think you would find any happier group of people than the staff in our agency if we were able to declare a victory and not have a CHC Program any longer because there were no more underserved areas in the United States. Whether that will occur in 5 years or 10 years or longer, no one knows. We are still struggling not only with a complex system but with a very complex response. It has not been the consensus of the Congress that there should be uniform entitlement to health services in the United States. Therefore, in an effort to provide an infrastructure, we have specific financing programs, we have specific capacity-building programs, and we have manpower training programs. Implicity, there is still a spectrum of access and availability problems that we are addressing.

Absent any real national policy that our local, State, and national systems ought to assure in some way access to services as a matter of policy, I suspect that we must anticipate that there will be a necessity over the next decade or two for continued targeted programs at the local, State, or national level to address what continue to be access problems. And whether those are financing programs or whether they are categorical or block grant programs, I suspect that we will have to deal with both of those issues, because we know that the sands are shifting. Although the good news is that 80 percent or more of Americans have some type of health insurance, the difficulty that we are dealing with is that 20 percent or so have little or no insurance. With that sort of complication, it is hard to project that in 5 years we can declare a victory and go home.

Senator Durenberger. And I am glad to get that reaction. I am just trying to—and it will take a while for me to do it, I'm sure—find out what role in particular the Public Health Service is playing. I watch my colleagues on the Labor and Human Resources Committee, and I know what they are doing. They are filling the cracks, so to speak. I see Orrin Hatch just popping up and down to get more money into Home Health because he doesn't see enough of it there.

So I am trying to search for some role that we play here. Every time we see a new problem that exists out there, or an opportunity sometimes, then there is a national responsibility to come along with the resources, and then hopefully, over time, having recognized that the problem can be solved and that the resources can be utilized in certain ways, then gradually it becomes a State, local, and to a degree, private sector can sort of move in and take over.

Is that kind of where we have been in our recent history in terms of using Federal authorization and appropriations in this area?

Dr. Graham. I believe it is not an unfair characterization. We may not be as far along the curve as we would like in all areas, but we have had an experience recently which, I think, gives some hope for optimism.

In 1981, the Community Health Centers' budget received an adjustment downward so that we could no longer support approximately 250 CHC's that we had supported in the prior year. Approximately, 60 percent of those community health centers continued to operate without Federal funding. That indicates to me that they had been able to establish roots in the community during the time of Federal support. They had become good business operations. These centers operate with boards that reflect the priorities and makeup of their community. Although it is always difficult and painful to discontinue grant funds, this is a success story. It indicates that as we go along this continuum we have some reason to expect that these entities will be able to become freestanding and not dependent upon Federal or State grants forever.

How soon can we phase out family medicine grants? How soon can we phase out CHC grants? I think that is the future toward which we are going. These are categorical programs put in place to address a need. We hope that these needs would be met and that the reasons for the categorical programs would disappear. Whether that is a 5-year success or a 15-year success depends upon the resolution of the constellation of issues that the committee is getting into.

Senator DURENBERGER. Maybe both of you can be responsive to this: Over the last several years, is there an increase or a decrease in the population that is utilizing programs that are at least partly federally financed that deliver both preventive and acute care health services? Is that population getting bigger or smaller?

Mr. SMITH. Let me talk about the overall Medicaid population. It peaked about 1977, I believe, and we are on a kind of plateau. There has been a relatively small decline since then in the total number of people receiving Medicaid services.

Dr. GRAHAM. In trying to answer that in terms of not only the populations under public assistance but perhaps those who we might term "medically indigent," we have to look at this question—and a number of people in the private sector have looked at it. It is an area of substantial disagreement, and I suspect that the panel this morning will reflect some of those areas of disagreement.

Our best judgment is that it is a fluctuating population, and that the degree to which you have individuals who are classified as medically indigent or who are eligible for Medicaid or any of the State assistance programs will depend upon the state of the economy, and upon the level of employment. There have been many studies on the effects of unemployment on access to services.

Overall, we do not have any firm data which indicate a decreased demand for services as delivered through our programs at the present time. As a matter of fact, this last year the federally funded, community health centers delivered services to more people than ever. Is the cup half full or half empty? In a way, we thought that was good, because it indicated that the centers are getting services to the people in the community they are supposed to serve. Does that mean that there are more people in those communities who are without health insurance or without the means to pay for their care? That is where the data becomes much softer. I have not seen any study or statistics which have shown beyond the shadow of a doubt that that population is growing or falling in any marked trend. It seems to me that we know that there is a population, that does not have day-to-day financial access to services, and that that is the population we are trying to serve. And we hope that overall, it is shrinking.

Senator DURENBERGER. Well, when we get to the third in this series of hearings we may pick up on this issue a little more. My concern is on the health side of health care, the prevention side, and probably needing to deal with the prevention issues—with nutrition, with shelter, with a lot of those kinds of things, where are we at in terms of the impact of the lack of appropriate expenditures in those areas and the impact that it is having on the acute care system.

Dr. GRAHAM. I would like to call to your attention a study released last year by the Robert Wood Johnson Foundation on access to services in America. You and the staff may have already reviewed it. Its message would indicate to us that there is generally a lot of optimism, that gains are being made. But it does identify certain pockets of continued problems. As you move into a third set of hearings, someone involved in this study could be helpful to the committee.

Senator DURENBERGER. Very good.

Gentlemen, thank you very much for your testimony. The rest of our questions we will submit to you for response in writing.

[The answers not available at press time.]

Senator DURENBERGER. Next we will have a panel consisting of Rick Curtis, Director of Health Policy Studies for the Center of Policy Research, National Governors Association; Dr. David Axelrod, Commissioner of Health for the State of New York; Dorothy Kearns, Guilford County, NC, on behalf of the National Association of Counties.

Welcome to the three of you.

Rick, why don't you begin. We have your statements. I think we have all of your statements. They will be made a part of the record, if you could summarize.

Let me say before you get going, I know we had some difficulty arranging to get a Governor here, and all that sort of thing; but I just want to say for the record that I would rather have you here than a whole lot of Governors. And I would say the same thing about myself, because I know how hard you and the rest of these people sitting back here work on the issues. So I am glad you couldn't find a Governor and were able to come here yourself, because this whole issue area of the economically disadvantaged—we are going to be heavily dependent on the Nation's Governors and county commissioners in the future to help us wrestle with this problem.

You may proceed.

STATEMENT OF RICK CURTIS, DIRECTOR OF HEALTH POLICY STUDIES FOR THE CENTER OF POLICY RESEARCH, NATIONAL GOVERNORS ASSOCIATION, WASHINGTON, DC

Mr. **Curtis**. I personally appreciate that. Professionally there is probably no correct response, so I will go directly into the testimony. [Laughter.]

The Governors appreciate your personal leadership, Mr. Durenberger, on this issue, and we appreciate the opportunity to participate in these hearings.

As you personally have brought to the attention of the Governors at our hearing on health care costs last December and in your personal meetings with several individual Governors, the health care market reforms now underway that you support, as well as most of the Governors, are improving price sensitivity but at the same time reducing the ability and willingness of private sector providers to cross-subsidize care for the medically indigent. While there are a variety of state and local programs to provide access for individuals not eligible for the Federal-State Medicaid Programs, these informal cross-subsidies by providers have been critically important as an indirect financing mechanism for financing care for the poor.

An understanding of the extent, nature, and adequacy of the existing programs at the State, Federal, and local levels is a critical step in designing effective approaches to solving the problem, and we therefore are very happy you are having this series of hearings, and we feel that the findings of these hearings will be of great benefit to the Governors as well as to this subcommittee.

Unfortunately, we do not currently have comprehensive information on the very diverse State programs to serve the economically disadvantaged. About the only safe generalization at this point is that you can't generalize about these programs; they are amazingly diverse.

We and our sister organizations, including the Intergovernmental Health Policy Project, NACO, the Academy for State and Local Government, and others, are actively now working on a variety of papers that will provide far better information in this regard, and we will be happy to submit them to you. All of them will be done by early December.

Senator **Durenberger**. By when?

Mr. **Curtis**. Early December, some of them before then. We will give them to your staff as soon as each is completed.

While we do not have comprehensive information on existing programs at this time, we can offer some initial observations and examples.

Many States do have a variety of programs that seek to afford access to health care for the non-Medicaid-eligible poor. No two States are identical with respect to important variables, including administrative structure, financing mechanisms, eligibility, and funding. In fact, very few of them are even remotely similar.

It might be helpful, though, to mention several categories as examples, just to give you an overall sense of what these programs look like.

In a majority of States, as NACO well knows, there are statutes generally called Health Care Responsibility Acts, which establish responsibility for local governments to act as a payor of last resort. Typically for emergency care, typically the nature of the program is left up to the local government.

Some States use general assistance income support funds for individual medical emergencies, without establishing a formal medical program. Examples of that approach include Vermont and Wisconsin. Other States make direct appropriations to selective providers who have a responsibility to serve the indigent, typically public teaching hospitals. Colorado and Iowa have relied on such an approach to date.

Two States that I want to mention specifically are very similar, and I'll go into why I want to mention them specifically a bit later. Michigan and Vermont have State funded general assistance health care programs for primary——

Senator **Durenburger**. Michigan and Virginia?

Mr. **Curtis**. Michigan and Virginia.

Well—for primary care services with State-set eligibility and income standards, really a Medicaid model for the ambulatory side. And they have, on the hospital side, a State and locally funded hospitalization program with voluntary local government participation and locally set eligibility and service standards.

Several States have State-run general assistance medical programs on both the hospital and ambulatory side which are similar but more limited than Medicaid. Maryland, Illinois, and your own State of Minnesota have that sort of program. Other programs that don't base eligibility purely on the basic of income and resources include disease-specific programs, population-specific programs, catastrophic programs, insurance pools. We have mentioned examples of each of those in the written testimony.

It should be noted, though, that with respect to arrangements like the private insurance pools, the Federal Employee Retirement Insurance Security Act largely exempts self-insured health insurance plans from State regulation. And as you well know, employers are increasingly self-insuring, making it more and more difficult for States to use pooling and similar private insurance-based arrangements to address the problems of the poor and underinsured, to require minimum benefit coverage, or a variety of other things. To the extent States do that, that makes it more and more attractive to self-insure, exacerbating the possible price differences between private insurers who are subject to such State regulations and self-insured entities who are not.

In addition to the separate programs for the indigents, State hospital rate-setting programs in New Jersey, Maryland, Massachusetts, and New York address in one way or another bad debt and/or charity care payments. An example that I know is of particular interest to you, in Florida one component that recently enacted cost-containment legislation creates a pool of funding for services for medically needed individuals not heretofore covered under State programs. By establishing an assessment on the net revenue of each hospital, the funding responsibility for this population is therefore more equitably distributed among all hospitals. This approach not only supports the provision of care for indigent individuals, it also helps to allow price competition among providers based on actual differences in efficiency because providers with relatively large amounts of charity care will be at a smaller relative competitive disadvantage.

It might be mentioned that New York, through its rate setting mechanism, has a similar pooling arrangement.

As you know, NGA has long said that basic income support programs for the poor should be a Federal rather than a State responsibility. One reason for that is, States with the most depressed economies that experience sharp reductions in state revenues during economic downturns, the sharpest reductions, simultaneously experience an increased need for income-support programs for the poor.

Now we will go back to Michigan and Virginia, which we happened to be able to get some data on from the intergovernmental health policy project and from the budget officers.

As I mentioned, programs for the medically indigent are very, very similar. The status of their economy in the most recent recession was not. From 1980 to 1983 as a result, Michigan State general fund revenues went up by like 4.2 percent over that whole 3-year period. In fact, from 1980 to 1981 they went down, while State expenditures on hospitalization for the indigent jumped 256 percent. That's 4.2 percent vis-a-vis 256 percent.

Virginia experienced a smaller unemployment rate. State revenues increased by 26 percent from 1980 to 1983, while expenditures on hospitalization for the medically needy increased by 44 percent over the 1980 level. And while as in most States the revenues weren't keeping up with health care costs and hospital costs more specifically, at least the difference was not so profound. I think this example underscores the problem with relying on State revenue and probably a local revenue structure to fund care for the medically indigent. This population in particular is very volatile with respect to the status of the local State economy, and as you well know, the local State revenue structures are as well. Unfortunately, they don't go in the same direction.

In sum, the Governors place a high priority on sustaining services under basic Federal income support programs for the poor, such as Medicaid; but we recognize that the Federal deficit precludes new programs requiring major new Federal expenditures.

It is important that Federal, State, and local governments and the private sector work together to find innovative solutions to the indigent care problem. Otherwise, the improvements underway in the health care marketplace may severely compromise the availability of health care for the poor.

Again, we greatly appreciate your individual efforts to find solutions to this critical problem.

Senator **Durenberger**. Dorothy, should we go to you next and give Dr. Axelrod more time to catch his breath?

[Mr. Curtis's written testimony follows:]

National Governors' Association

John Carlin
Governor of Kansas
Chairman

Raymond C. Scheppach
Executive Director

TESTIMONY OF

RICHARD E. CURTIS

DIRECTOR OF HEALTH POLICY STUDIES, OFFICE OF RESEARCH AND DEVELOPMENT

NATIONAL GOVERNORS' ASSOCIATION

BEFORE THE

SENATE FINANCE COMMITTEE
SUBCOMMITTEE ON HEALTH

REGARDING

AN OVERVIEW OF EXISTING STATE HEALTH PROGRAMS FOR THE ECONOMICALLY DISABLED

SEPTEMBER 28, 1984

HALL OF THE STATES · 444 North Capitol Street · Washington, D.C. 20001 · (202) 624-5300

MR. CHAIRMAN, WE APPRECIATE THE OPPORTUNITY TO PARTICIPATE IN THIS HEARING, AND WOULD LIKE TO THANK YOUR FOR YOUR PERSONAL INTEREST AND LEADERSHIP REGARDING ACCESS TO HEALTH CARE FOR THE ECONOMICALLY DISADVANTAGED. AS YOU HAVE BROUGHT TO THE ATTENTION OF THE GOVERNORS, THE HEALTH CARE MARKET REFORMS NOW UNDERWAY THAT ARE IMPROVING PRICE SENSITIVITY ARE ALSO MAKING IT INCREASINGLY DIFFICULT FOR PROVIDERS TO FUND CARE FOR POOR INDIVIDUALS THROUGH PRICE INCREASES TO PRIVATE PATIENTS. ALTHOUGH A VARIETY OF DIRECT STATE AND LOCAL PROGRAMS EXIST TO PROVIDE ACCESS FOR INDIGENT INDIVIDUALS NOT ELIGIBLE FOR MEDICAID, SUCH CROSS SUBSIDIES HAVE BEEN A CRITICALLY IMPORTANT INDIRECT MECHANISM FOR FINANCING CARE FOR THE POOR. BECAUSE IT IS INCREASINGLY DIFFICULT FOR HOSPITALS AND OTHER PROVIDERS TO CONTINUE THESE PRACTICES, FEDERAL AND STATE POLICIES SHOULD BE CAREFULLY DESIGNED TO FACILITATE RATHER THAN COMPROMISE ACCESS TO NEEDED CARE FOR THE ECONOMICALLY DISADVANTAGED. AN UNDERSTANDING OF THE EXTENT, NATURE AND ADEQUACY OF EXISTING PROGRAMS AND POLICIES IS A CRITICAL STEP IN DESIGNING EFFECTIVE APPROACHES. THE INFORMATION YOU ARE GATHERING THROUGH THIS HEARING WILL THEREFORE BE OF SIGNIFICANT BENEFIT TO THE GOVERNORS AS WELL AS TO YOUR SUBCOMMITTEE, AND WE GREATLY APPRECIATE YOUR CONCERN AND INITIATIVE IN THIS REGARD.

UNFORTUNATELY, WE DO NOT CURRENTLY HAVE COMPREHENSIVE INFORMATION ON THE VERY DIVERSE STATE PROGRAMS TO SERVE THE ECONOMICALLY DISADVANTAGED. WE ARE NOW, HOWEVER, PARTICIPATING IN SEVERAL ACTIVITIES DESIGNED TO PROVIDE MORE COMPLETE INFORMATION ON

EXISTING STATE AND LOCAL PROGRAMS AND POLICY OPTIONS TO SERVE THE MEDICALLY INDIGENT. DOCUMENTS ON THESE ISSUES WILL BE COMPLETED BY EARLY DECEMBER, AND WE AND OUR SISTER ORGANIZATIONS WILL BE PLEASED TO SUBMIT COPIES TO THE SUBCOMMITTEE. THEY INCLUDE:

- SUMMARY PROFILES OF EXISTING STATE INDIGENT CARE PROGRAMS BASED UPON A FIFTY SURVEY BY THE INTERGOVERNMENTAL HEALTH POLICY PROJECT (IHPP), GEORGE WASHINGTON UNIVERSITY.

- A COMPILATION OF ALTERNATIVE PROPOSALS UNDER CONSIDERATION OR DEVELOPMENT BY STATE EXECUTIVE BRANCH OR LEGISLATIVE BODIES, BASED UPON SURVEYS BY NGA AND IHPP.

- A BACKGROUND PAPER ANALYZING THE LEGAL RESPONSIBILITY OF INDIVIDUAL STATE AND/OR LOCAL GOVERNMENTS PURSUANT TO RELEVANT STATE LAWS AND JUDICIAL DECISIONS, BASED ON A SURVEY CONDUCTED BY THE NATIONAL ASSOCIATION OF COUNTIES AND TO BE PREPARED AND PUBLISHED BY THE ACADEMY FOR STATE AND LOCAL GOVERNMENT.

- CASE STUDIES OF SELECTED MODEL STATE AND LOCAL PROGRAMS, WHICH WILL INCLUDE INFORMATION ON FINANCING MECHANISMS, POPULATIONS SERVED, AND SERVICES COVERED. TO BE PREPARED AND PUBLISHED THROUGH THE ACADEMY FOR STATE AND LOCAL GOVERNMENT.

- A policy option paper outlining structural options available at the state and local level to finance and deliver health care for the medically indigent, prepared and published through the Academy for State and Local Government.

While we do not now have comprehensive information on existing programs to serve the economically disadvantaged, we can offer some initial observations and examples. Many states have a variety of programs that seek to afford access to health care for this population. No two states are idential with respect to important variables such as administrative structure, service coverage, eligibility and funding. However, for purposes of presentation and analysis it may be useful to place public financing programs on a continuum, arranged by extent of coverage and state involvement, from most limited to most comprehensive and formal.

- In a majority of states, state statutes establish legal responsibility for local governments to act as a payor or provider of last resort for the indigent, typically for emergency care. Usually, the nature of programs is left to the discretion of local entities. Examples of states that have largely or exclusively used this approach are Indiana and Texas.

- Another approach is the use of state General Assistance funds for individual emergencies for state only income support program eligibles, without establishing a formal medical program. Examples are Vermont and Wisconsin.

- Some states make limited appropriations to providers that have responsibility to serve the indigent, typically public teaching hospitals. Colorado and Iowa rely on such an approach.

- Two states (Michigan and Virginia) have a state funded General Assistance health care program for primary care services with state set eligibility and income standards, and a state and locally funded hospitalization program, with voluntary local government participation, and locally set eligibility and service standards.

- Several states have state-run General Assistance medical programs which are similar to Medicaid. However, service limitations, cost sharing requirements and income and resource standards tend to be tighter than under Medicaid. States with this approach include Maryland, Minnesota and Illinois. As you know, 1982 Medical reforms converted California's state funded and administered program for Medically Indigent Adults to a

COUNTY RESPONSIBILITY, WITH A FIXED STATE APPROPRIATION BASED UPON HISTORIC COSTS OF THE STATE-RUN SYSTEM.

RELATED STATE PROGRAMS THAT DO NOT BASE ELIGIBILITY PURELY ON INCOME AND RESOURCES INCLUDE:

1) DISEASE SPECIFIC PROGRAMS, SUCH AS THOSE FOR
   - HEMOPHILIA, E.G. WISCONSIN'S
   - CANCER PROGRAMS, E.G. MISSOURI'S
   - HEART DISEASE PROGRAMS, E.G. NORTH CAROLINA'S
   - SICKLECELL ANEMIA, E.G. NEW YORK'S

2) POPULATION SPECIFIC PROGRAMS, SUCH AS THOSE FOR

   - INDIANS OR NATIVE AMERICANS, E.G. WISCONSIN
   - MIGRANT WORKERS, E.G. MICHIGAN
   - IMMIGRANTS, E.G. FLORIDA
   - MOTHERS AND CHILDREN THROUGH MATERNAL AND CHILD HEALTH AND SIMILAR PROGRAMS IN ALL STATES

3) MECHANISMS TO PROVIDE PROTECTION FOR INDIVIDUALS WHO ARE UNINSURABLE OR WHO EXPERIENCE CATASTROPHIC MEDICAL CARE COSTS.

   - CATASTROPHIC PROGRAMS SUCH AS RHODE ISLAND AND ALASKA
   - INSURANCE POOLS SUCH AS INDIANA, CONNECTICUT, FLORIDA AND MINNESOTA

IT SHOULD BE NOTED THAT INSURANCE POOLS PROVIDE AN OPPORTUNITY TO PURCHASE INSURANCE FOR INDIVIDUALS WHO ARE NOT CONSIDERED INSURABLE BY INDIVIDUAL COMPANIES, SUCH AS PERSONS WITH PRE-EXISTING CONDITIONS. THEY GENERALLY DO NOT PROVIDE FINANCIAL ACCESS FOR POOR INDIVIDUALS.

FURTHER, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) LARGELY EXEMPTS SELF-INSURED HEALTH CARE PLANS FROM STATE REGULATION. THEREFORE, AS EMPLOYERS INCREASINGLY SELF-INSURE, IT IS MORE AND MORE DIFFICULT FOR STATES TO USE POOLING AND SIMILAR PRIVATE INSURANCE- BASED ARRANGEMENTS TO ADDRESS THE PROBLEMS OF THE POOR AND UNDER-INSURED. IF STATES DO ADOPT SUCH STRATEGIES, THE CONCOMITANT COSTS BORNE BY INSURERS SUBJECT TO STATE REQUIREMENTS MAY MAKE THOSE INSURERS' PLANS MORE COSTLY THAN SELF-INSURANCE, PROVIDING A FURTHER IMPETUS FOR PURCHASERS TO SELF-INSURE. THIS IS THEREFORE AN IMPORTANT AREA FOR FURTHER CONSIDERATION BY THE CONGRESS.

IN ADDITION TO THESE SEPARATE PROGRAMS FOR INDIGENT AND UNDER-INSURED INDIVIDUALS, STATE HOSPITAL RATE-SETTING PROGRAMS IN NEW JERSEY AND MARYLAND INCLUDE BAD DEBT AND CHARITY CARE PAYMENTS IN HOSPITAL RATES FOR ALL INSURERS, WHILE IN MASSACHUSETTES, ONLY CHARITY COSTS ARE INCLUDED BUT MEDICARE AND MEDICAID ALSO PARTICIPATE IN PAYMENT OF THESE COSTS.

Florida and New York have designed similar medically indigent financing mechanisms that are compatible with either market or regulatory cost containment approaches.

In Florida, one component of recently enacted cost containment legislation creates a pool of funding for services to medically needy individuals not heretofore covered under state programs. By establishing an assessment on the net revenue of each hospital, the funding responsibility for this population is distributed more equitably among hospitals. These revenues, along with federal Medicaid matching funds and a small general revenue appropriation, will be used to reimburse providers for services rendered to medically needy individuals. Providers with a larger medically needy caseload will realize a directly proportionate share of revenue and a reduced need to cross-subsidize through increased charges to private payers. State estimates indicate that funds will be sufficient only for expansions in state Medicaid program coverage of the medically needy but will not be sufficient to fund care for other medically indigent populations at this time.

This approach not only supports the provision of care for indigent individuals, but also helps to allow price competition among hospitals based on actual differences in efficiency. Hospitals providing relatively large amounts of charity care will be at a smaller competitive disadvantage. While Florida's cost containment legislation does provide standby regulatory control

FOR AREAS AND HOSPITALS THAT EXCEED TARGETS, THE STATE CONTINUES TO SUPPORT THE DEVELOPMENT OF EFFECTIVE MARKET FORCES TO CONTROL COSTS IN THE LONG-RUN.

NEW YORK ADDRESSES THE FINANCING OF INDIGENT CARE THROUGH POOLNG MECHANISMS CONTAINED IN ITS ALL-PAYER RATE SETTING METHODOLOGY. THE STATE IS SEPARATED INTO EIGHT REGIONAL POOLS. EACH PAYER IS SURCHARGED A PERCENTAGE OF THEIR HOSPITAL REIMBURSEMENT. EACH HOSPITAL REPORTS ITS INPATIENT AND OUTPATIENT EXPENSES ATTRIBUTABLE TO BAD DEBT AND CHARITY CARE.

AS YOU KNOW, THE NATIONAL GOVERNORS' ASSOCIATION BELIEVES THAT BASIC INCOME SUPPORT RELATED PROGRAMS FOR THE POOR ARE APPROPRIATELY A FEDERAL RATHER THAN STATE RESPONSIBILITY. THIS IS IN PART BECAUSE STATES WITH THE LARGEST INDIGENT POPULATIONS OFTEN ARE LEAST ABLE TO FUND PROGRAMS TO ASSIST THEM. THIS IS PARTICULARLY TRUE OF MEDICAL CARE FINANCING PROGRAMS BECAUSE MEDICAL CARE COSTS OFTEN CONTINUE TO ESCALATE REGARDLESS OF GENERAL ECONOMIC CONDITIONS, AND CANNOT BE EFFECTIVELY CONTROLLED BY STATE ADMINISTRATION OF PROGRAMS FOR THE POOR. STATES WITH THE MOST DEPRESSED ECONOMIES AND RESULTING SHARP REDUCTIONS IN STATE REVENUES SIMULTANEOUSLY EXPERIENCE AN INCREASED NEED FOR INCOME SUPPORT PROGRAMS FOR THE POOR. THIS IS PARTICULARLY TRUE FOR THE WORKING POOR, INDIGENT SINGLE ADULTS AND CHILDLESS COUPLES COVERED BY PROGRAMS FOR THE MEDICALLY INDIGENT. STATES WITH CHRONICALLY HIGH CONCENTRATIONS OF POOR PERSONS ALSO HAVE VERY LIMITED RESOURCES TO MEET THEIR MEDICAL NEEDS.

To illustrate this problem, it might be helpful to review recent data from two states which happen to have roughly similar programs for the medically indigent, Michigan and Virginia.

The following table summarizes the state general fund revenue data for the period 1980 to 1983.

State General Fund Revenues, in millions of dollars
(Source: National Association of State Budget Officers)

Fiscal Year	1980	1981	1982	1983
Michigan	4,720	4,386	4,445	4,919
Virginia	2,392	2,582	2,834	3,029

Michigan, which was particularly hard hit by the recession, experienced a revenue a drop of 7.1% from 1980 to 1981. During this same period, state expenditures on hospitalizatin for the medically indigent went from $13.9 million to $24.9 million, a 79% increase. (According to data collected by the Intergovernmental Health Policy Project.) From 1980 to 1983, state general fund revenues went up by only 4.2% while state expenditives on hospitalization jumped to $49.5 million, 256% over the 1980 level. (The recipient count was 13,185 in 1983, or 114% over the 6, 139 recipient count in 1980.)

THIS EXTRAORDINARY DIFFERENCE BETWEEN GROWTH IN STATE REVENUES AND HOSPITALIZATION EXPENDITURES IS IN CONTRAST WITH THE EXPERIENCE IN VIRGINIA WHICH EXPERIENCED A SMALLER UNEMPLOYMENT RATE VIRGINIA STATE REVENUES INCREASED BY 26.6% FROM 1980 TO 1983 WHILE EXPENDITURES ON HOSPITALIZATIN FOR THE MEDICALLY INDIGENT INCREASED FROM $5.7 MILLION TO $8.2 IN 1983, OR 44% OVER THE 1980 LEVEL.

THESE FUNDING PATTERNS UNDERSCORE THE PROBLEMS WITH PROGRAMS FOR THE MEDICALLY INDIGENT FINANCED EXCLUSIVELY BY STATE AND LOCAL GENERAL FUNDS. DURING ECONOMIC DOWNTURNS, UNEMPLOYMENT AND THE UNINSURED POPULATION INCREASE, STATE AND LOCAL REVENUES FALL, AND HEALTH CARE COST INCREASES TEND TO CONTINUE UNABATED. ONE ADVANTAGE OF A FINANCING SOURCE LINKED TO HOSPITAL REVENUES, SUCH AS FLORIDA'S, IS THAT FUNDS INCREASE AT THE SAME RATE AS HOSPITAL COSTS.

WHILE A LARGE NUMBER OF STATES HAVE LEGISLATION THAT ESTABLISHES OR SUGGESTS RESPONSIBILITY FOR THE MEDICALLY INDIGENT, THIS APPROACH MAY NOT BE ADEQUATE AS THE POLICY AND MARKET ENVIRONMENT CHANGE. IN TEXAS, FOR EXAMPLE, THE STATE CONSTITUTION AND STATUTORY LANGUAGE STATE THAT COUNTIES ARE RESPONSIBLE FOR PROVIDING MEDICAL CARE TO THEIR INDIGENT RESIDENTS. THE COUNTY COMMISSIONERS, COURT OR THE HOSPITAL DISTRIST DETERMINES ELIGIBILITY AND THE EXTENT OF THE SERVICE AND FINANCIAL OBLIGATION, PRIMARILY ON A CASE-BY-CASE BASIS. IN RECENT YEARS, THE INADEQUACIES OF THIS SYSTEM HAVE COME UNDER ATTACK FROM

DIFFERENT SIDES. ADVOCATES FOR THE INDIGENT ARGUE FOR BETTER ACCESS TO NEEDED SERVICES. HOSPITALS COMPLAIN THAT THEY ARE NOT BEING REIMBURSED FOR SERVICES TO THE INDIGENT. AND COUNTIES ARE SEEKING RELIEF FROM THE INCREASING COSTS OF INDIGENT CARE. THE GOVERNOR HAS APPOINTED A COMMISSION TO RECOMMEND ACTIONS WHICH ADDRESS THE INDIGENT CARE PROBLEM.

THE GOVERNORS ARE VERY CONCERNED ABOUT THE FEDERAL BUDGET DEFICIT, AND BELIEVE IT MUST BE REDUCED IN ORDER TO SUSTAIN ECONOMIC GROWTH. THE GOVERNORS PLACE A HIGH PRIORITY ON SUSTAINING SERVICES UNDER BASIC FEDERAL INCOME SUPPORT PROGRAMS FOR THE POOR SUCH AS MEDICAID, BUT RECOGNIZE THAT THE DEFICIT PRECLUDES NEW PROGRAMS THAT REQUIRE MAJOR FEDERAL EXPENDITURES. IT IS IMPORTANT THAT FEDERAL, STATE AND LOCAL GOVERNMENTS AND THE PRIVATE SECTOR WORK TOGETHER TO FIND INNOVATIVE SOLUTIONS. OTHERWISE, THE IMPROVEMENTS UNDERWAY IN THE HEALTH CARE MARKETPLACE MAY SEVERELY COMPROMISE THE AVAILABILITY OF NEEDED HEALTH CARE FOR THE POOR. AGAIN, WE APPRECIATE YOUR EFFORTS TO FIND SOLUTIONS TO THIS CRITICAL PROBLEM.

STATEMENT OF DOROTHY KEARNS, COMMISSIONER, GUILFORD COUNTY, NC, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES, WASHINGTON, DC

Ms. KEARNS. Thank you.

It is a great pleasure for me to be here. The National Association of Counties appreciates your committee's recognition of the problem of indigent health care and the role played by local government.

I serve as a member of NACO's Health and Education Steering Committee, and I am here on behalf of the National Association of Counties. In Guilford County I am on the Mental Health/Mental Retardation and Substance Abuse Board. Prior to becoming a county commissioner I served for 10 years as a locally elected school board member and as an appointed member of the Guilford County Board of Health for 4 years.

I am proud to tell you that the Guilford County Board of Health, established in 1911, was the first county board of health in the Nation.

Because we have two major cities, the third and the sixth largest in our State, our county has two health departments. In our county, where we have a budget of $119 million, payments for indigent care total $10 million which is all drawn from county property taxes.

In North Carolina counties match the State's share of Medicaid, and this year, through our department of social services, we will pay over a million and a half dollars in Medicaid-match money.

In our two health departments we have traditionally placed an emphasis on outpatient and primary care to provide health care to the indigent. As the cost of medical care has risen and revenues have become tighter, we have necessarily had to concentrate on meeting treatment needs first. Our past experience is that preventive programs are cost-effective in the long run; thus we are concerned at any prospect of necessary sustained deemphasis on prevention.

I am here to speak to you today on the role of our Nation's counties in financing and providing health care to the poor, and to make some general observations and recommendations regarding the problem of indigent health care.

For many decades, counties have provided and have increasingly financed last-resort health care services to the poor, either through vendor payments to private doctors and hospitals or in their own hospitals and clinics.

Nationwide, county governments are charged by the States with fulfilling this traditional and statutory responsibility for financing indigent care and providing health care and other social services. Thirty-four States hold counties legally liable for indigent care.

We have an indigent health care problem in this country because we have not resolved the very tough issue of responsibility. Since we have not done so, the courts are beginning to make some of these decisions for us. Lawsuits against counties for indigent care are common, and the courts' rulings against counties are alarming.

Through cost shifting and by sometimes turning away from the disenfranchised, we have failed to deal effectively enough with the question of phsyical, legal, and moral responsibility for health care of the poor. The intergovernmental responsibility is particularly unresolved.

Senator **Durenberger**. Dorothy, let me stop you right there. I just want to reinforce those last three or four sentences. That is the primary reason why we are having these hearings, that somebody—either I, or at the Governors level, or at the county level, or some understood combination—has to take responsibility for this.

Ms. **Kearns**. And it is very difficult for the public to know who to ask for, from whom.

Senator **Durenberger**. Yes. I happen to think this is where the responsibility lies. As a nation we shouldn't be forcing people to vote with their feet. I think you can do a lot better job of meeting the needs; but until I acknowledge my responsibility, we are going to have a hard time sorting these things out. I am glad you made that point.

Ms. **Kearns**. I appreciate your comments there very much.

The end of my sentence there was: How shall we have and establish a good balance between treatment and prevention?

We are well aware of the consequences of not resolving this issue. Quite simply stated, health care costs are astronomical, and the state of some of our people's health is unacceptable.

While we are spending over 1 billion a day on health care, there are still over 38 million uninsured Americans. We produce the second greatest number of low birth weight babies among Western countries, and neonatal intensive care is the single largest portion of uncompensated care costs.

There are hundreds of thousands of homeless without health coverage. Half of our preschool children are not immunized, and our elderly are increasingly unable to cover their health care needs.

We face all of this, in spite of a growing deficit and exhorbitant public spending, which ignites taxpayer revolts at all levels of government. As governments closest to the people, counties are painfully aware of this growing indigent population and the constraints of resources with which to serve them.

These limitations include regulatory policies within the health care delivery systems such as rate setting, which prevents shifting costs across payors to fund indigent care, and competition among providers which excludes those who cannot pay.

If we are to provide effectively for health care needs of the indigent, we must first resolve some basic issues the roles of different levels of government; the roles of the public and private sectors; and the capacity of our present political system to make these hard decisions and to set priorities.

A Federal legislative strategy for indigent care should: (1) Define "indigent care." We strongly advised that policies not be derived from ideas that focus predominately on subsidizing providers for uncompensated care, though we think uncompensated care must be addressed.

The costly institutional bias of the Medicare and Medicaid programs should be a lesson to us to orient programs toward keeping individuals healthy, as opposed to solely a provider-oriented approach.

Also, an attempt to define "indigent care" should not overlook the elderly, as counties are faced with severe shortages in resources for their care.

Senator Durenberger, I was particularly impressed by things which came before our county commission meeting yesterday—a request for six additional positions, nurses, aids, and clerk typists, in the home health service area. And I did bring for your record a brochure which tells about our home health efforts. We have found that since the DRGs have come into effect, we have a lot of elderly people leaving the hospitals early who still have great needs which they cannot take care of at home. And we have had such an increase of requests for these services that we did put in those six positions yesterday; we felt we absolutely had to.

Senator DURENBERGER. Are you getting near the end of your comments?

Ms. KEARNS. Well, not really. I need to move along quickly.

Senator DURENBERGER. We need to have you try. Your full statement will be made a part of the record.

Ms. KEARNS. Exactly. Just stop me whenever you want me to stop, then. [Laughter.]

I'm going to say all that I can.

Senator DURENBERGER. If I could do it in a nice way, I would. [Laughter.]

Ms. KEARNS. OK. Just another minute or two.

Senator DURENBERGER. In conclusion——

[Laughter.]

Ms. KEARNS. We want to recognize and resolve conflicting policies. For example, we don't want to mandate employee-employer based insurance. Mandating employer-based insurance may be an effective way to expand health care, but it is problematic at a time when business is questioning its role in paying for health care.

Also, we do not want to gravitate too quickly to a particular policy or program, calling for its duplication as a panacea for all our indigent care problems.

Finally, an effective solution to indigent health care should do the following:

Involve local government as prudent purchasers and providers of care. Why do I say this? Local governments have the incentive to provide quality care in the most cost effective manner because we are legally and financially liable. Local governments are also closest to the people being served, and we feel we are in a good position to know the needs of the population. We can target resources effectively and spot problems before it is too late and develop those unique arrangements of resources to meet the specific problem.

I have some specific examples of that, also.

Local governments have a traditional and historical role in public health and can apply their resources and experience in this effort to developing basic health care plans for the indigent.

Furthermore, an indigent health care policy should provide insurance coverage, preferably on a prepaid capitated basis such as HMO memberships for the indigent, and allow for local government or intercounty compacts.

Senator DURENBERGER. That's a good place to end.

Ms. KEARNS. Just go ahead?

Senator **Durenberger**. No; I said that's a good place to end. [Laughter.]

Ms. **Kearn**. We will be sure to give you all of this.

Senator **Durenberger**. I have already incorporated all of that in the record. Thank you, Dorothy, very much. Dr. Axelrod?

[Ms. Kearn's written testimony follows:]

STATEMENT OF DOROTHY KEARNS, COMMISSIONER, GUILFORD COUNTY, NORTH CAROLINA, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES* (NACo), BEFORE THE SENATE COMMITTEE ON FINANCE, SUBCOMMITTEE ON HEALTH.

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM DOROTHY KEARNS, COUNTY COMMISSIONER, GUILFORD COUNTY, NORTH CAROLINA. I AM HERE ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES, (NACo).*

I AM A MEMBER OF NACo'S HEALTH AND EDUCATION STEERING COMMITTEE. IN GUILFORD COUNTY, I SERVE ON THE AREA MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE BOARD AND PRIOR TO BEING ELECTED TO THE COUNTY COMMISSION, I SERVED FOR TEN YEARS AS A LOCALLY ELECTED SCHOOL BOARD MEMBER, AND AS AN APPOINTED MEMBER ON THE GUILFORD COUNTY BOARD OF HEATLH FOR FOUR YEARS. I AM PROUD TO SAY THAT THE GUILFORD COUNTY BOARD OF HEALTH, ESTABLISHED IN 1911, WAS THE FIRST COUNTY BOARD OF HEALTH IN THE NATION.

OUR COUNTY HAS TWO HEALTH DEPARTMENTS. IN OUR COUNTY, WHERE WE HAVE A BUDGET OF $119 MILLION, PAYMENTS FOR INDIGENT CARE TOTAL ALMOST $10 MILLION, 55% OF WHICH IS DRAWN DIRECTLY FROM COUNTY TAXES. ASIDE FROM OUR INDIGENT CARE RESPONSIBILITIES, COUNTIES IN NORTH CAROLINA MATCH THE STATE'S SHARE OF MEDICAID AND GUILDFORD COUNTY WILL PAY OVER $1.5 MILLION IN MEDICAID MATCH DOLLARS THIS YEAR. WE HAVE TWO HEALTH DEPARTMENTS, AND HAVE PLACED AN EMPHASIS ON OUTPATIENT AND PRIMARY CARE TO PROVIDE HEALTH CARE TO THE INDIGENT.

I AM HERE TO SPEAK TO YOU TODAY ON THE ROLE OF OUR NATION'S

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*NACo IS THE ONLY NATIONAL ORGANIZATION REPRESENTING COUNTY GOVERNMENT IN AMERICA. ITS MEMBERSHIP INCLUDES URBAN, SUBURBAN AND RURAL COUNTIES JOINED TOGETHER FOR THE COMMON PURPOSE OF STRENGTHENING COUNTY GOVERNMENT TO MEET THE NEEDS OF ALL AMERICANS. BY VIRTUE OF A COUNTY'S MEMBERSHIP, ALL ITS ELECTED AND APPOINTED OFFICIALS BECOME PARTICIPANTS IN AN ORGANIZATION DEDICATED TO THE FOLLOWING GOALS: IMPROVING COUNTY GOVERNMENT; ACTING AS A LIAISON BETWEEN THE NATION'S COUNTIES AND OTHER LEVELS OF GOVERNMENT; AND ACHIEVING THE PUBLIC UNDERSTANDING OF THE ROLE OF COUNTIES IN THE FEDERAL SYSTEM.

COUNTIES IN FINANCING AND PROVIDING HEALTH CARE TO THE POOR AND TO MAKE SOME GENERAL OBSERVATIONS AND RECOMMENDATIONS REGARDING THE PROBLEM OF INDIGENT HEALTH CARE. NACo COMMENDS THIS COMMITTEE FOR TAKING THE LEAD BY HOLDING HEARINGS ON THIS IMPORTANT ISSUE. WE THANK YOU FOR THE OPPORTUNITY TO PRESENT OUR VIEWS BEFORE THIS COMMITTEE. COUNTIES LOOK FORWARD TO CONTINUED DIALOGUE BETWEEN ALL LEVELS OF GOVERNMENT ON HOW BEST TO MEET THE HEALTH CARE NEEDS OF THE UNINSURED, MOST VULNERABLE POPULATIONS. ONLY BY RECOGNIZING THE MUTUALITY OF OUR LONG TERM INTEREST WILL RESPONSIBLE POLICIES AND PROGRAMS BE POSSIBLE.

DEFINING THE PROBLEM

WE HAVE AN INDIGENT HEALTH CARE PROBLEM IN THIS COUNTRY BECAUSE WE HAVE FAILED TO RESOLVE THE TOUGH QUESTION OF RESPONSIBILITY. SINCE WE HAVE NOT DONE SO, THE COURTS ARE BEGINNING TO MAKE THESE DECISIONS FOR US. LAWSUITS AGAINST COUNTIES FOR INDIGENT CARE ARE COMMON AND THE COURTS' RULINGS AGAINST COUNTIES ARE ALARMING.

THROUGH COST SHIFTING, AND BY TURNING AWAY FROM THE DISENFRANCHISED, THIS NATION HAS FAILED TO DEAL WITH THE QUESTION OF FISCAL, LEGAL AND MORAL RESPONSIBILITY FOR HEALTH CARE OF THE POOR. THE INTERGOVERNMENTAL RESPONSIBILITY IS PARTICULARLY UNRESOLVED.

WE ARE ALL WELL AWARE OF THE CONSEQUENCES. QUITE SIMPLY STATED, HEALTH CARE COSTS ARE ASTRONOMICAL AND THE STATE OF OUR NATION'S HEALTH IS UNACCEPTABLE. HEALTH CARE IS STILL THE MOST INFLATIONARY SECTOR OF THE ECONOMY. IN 1983, THE COST OF MEDICAL CARE ROSE AT A TEN PERCENT RATE, MORE THAN TRIPLE THE 3.2 PERCENT INCREASE IN THE OVERALL CONSUMER PRICE INDEX. WHILE WE ARE SPENDING OVER A BILLION

DOLLARS A DAY ON HEALTH CARE, THERE ARE STILL OVER 38 MILLION UNINSURED AMERICANS; WE PRODUCE THE SECOND GREATEST NUMBER OF LOW BIRTH WEIGHT BABIES AMONG WESTERN COUNTRIES; AND NEONATAL INTENSIVE CARE IS THE SINGLE LARGEST PORTION OF UNCOMPENSATED CARE COSTS. THERE ARE HUNDREDS OF THOUSANDS OF HOMELESS WITHOUT HEALTH COVERAGE; HALF OF OUR PRESCHOOL CHILDREN ARE NOT IMMUNIZED; AND OUR ELDERLY ARE INCREASINGLY UNABLE TO COVER THEIR HEALTH CARE NEEDS.

WE FACE ALL OF THIS, IN SPITE OF A GROWING DEFICIT, AND EXHORBITANT PUBLIC SPENDING, WHICH IGNITES TAX PAYOR REVOLTS AT ALL LEVELS OF GOVERNMENT. AS THE GOVERNMENTS CLOSEST TO THE PEOPLE, COUNTIES ARE PAINFULLY AWARE OF THIS GROWING INDIGENT POPULATION, AND THE CONSTRAINTS OF SEVERE RESOURCES TO SERVE THEM WITH. THESE LIMITATIONS INCLUDE REGULATORY POLICIES WITHIN THE HEALTH CARE DELIVERY SYSTEM, SUCH AS RATE SETTING, WHICH PREVENTS SHIFTING COSTS ACROSS PAYORS TO FUND INDIGENT CARE, AND COMPETITION AMONG PROVIERS WHICH EXCLUDES THOSE WHO CANNOT PAY.

RECOMMENDATIONS

IF WE ARE TRULY INTENT ON PROVIDING FOR THE HEALTH CARE NEEDS OF THE INDIGENT, WE MUST FIRST RESOLVE THESE BASIC ISSUES:

1. THE ROLES OF THE DIFFERENT LEVELS OF GOVERNMENT;
2. THE ROLES OF THE PUBLIC AND PRIVATE SECTORS; AND
3. THE CAPACITY OF OUR PRESENT POLITICAL SYSTEM TO MAKE THESE DECISIONS AND SET PRIORITIES.

SPECIFICALLY, A FEDERAL LEGISLATIVE STRATEGY FOR INDIGENT CARE SHOULD:

1. DEFINE INDIGENT CARE. WE STRONGLY ADVISE THAT POLICIES NOT BE DERIVED FROM IDEAS THAT FOCUS PREDOMINANTLY

ON SUBSIDIZING PROVIDERS FOR UNCOMPENSATED CARE. THE COSTLY INSTITUTIONAL BIAS OF THE MEDICARE AND MEDICAID PROGRAMS SHOULD BE A LESSON TO US TO ORIENT PROGRAMS TOWARD KEEPING INDIVIDUALS HEALTHY, AS OPPOSED TO A PROVIDER ORIENTED APPROACH. ALL LEVELS OF GOVERNMENT SHOULD BE USED TO IMPLEMENT PROGRAMS. AN ATTEMPT TO DEFINE INDIGENT CARE SHOULD NOT OVERLOOK THE ELDERLY, AS COUNTIES ARE FACED WITH SEVERE SHORTAGES IN RESOURCES FOR THEIR CARE.

2. RECOGNIZE AND RESOLVE CONFLICTING POLICIES. FOR EXAMPLE, MANDATING EMPLOYER-BASED INSURANCE MAY BE AN EFFECTIVE WAY TO EXPAND HEALTH CARE COVERAGE TO THE UNINSURED. BUT SUCH A MANDATE IS UNREALISTIC AT A TIME WHEN BUSINESS IS QUESTIONING THEIR ROLE IN PAYING FOR HEALTH CARE, AND THEIR CONCERNS ABOUT THE GROWING COSTS HAVE NOT BEEN ALLAYED.

3. NOT GRAVITATE TOO QUICKLY TO A PARTICULAR POLICY OR PROGRAM THAT OFFERS A GLIMMER OF HOPE, CALLING FOR ITS DUPLICATION AS A PANACEA FOR ALL OF OUR INDIGENT CARE PROBLEMS. FLORIDA'S RECENTLY PASSED LEGISLATION WHICH TAXES HOSPITALS' NET REVENUES AND CREATES A POOL OUT OF WHICH TO FUND INDIGENT CARE IS A CASE IN POINT. THIS LEGISLATION, DEVELOPED IN CONSULTATION WITH COUNTIES, REPRESENTS A GOOD ATTEMPT TO ADDRESS INDIGENT CARE, WITHOUT IMPOSING ALL-PAYOR RATE SETTING MECHANISMS. BUT, INDIGENT CARE WILL STILL REMAIN A MAJOR PROBLEM IN FLORIDA. THE INSTITUTIONAL PIECE WILL BE TAKEN CARE OF; MEDICAID WILL BE EXPANDED; AND $10 MILLION WILL GO

TO COUNTY HEALTH DEPARTMENTS TO DEVELOP PRIMARY HEALTH CARE SYSTEMS FOR THE INDIGENT. THIS $10 MILLION TO DEVELOP PREVENTIVE AND BASIC HEALTH CARE THAT WILL KEEP PEOPLE HEALTHY AND CONTROL COSTS, IS A MERE DROP IN THE BUCKET.

4. FINALLY, AN EFFECTIVE SOLUTION TO INDIGENT HEALTH CARE SHOULD DO THE FOLLOWING:

   A. INVOLVE LOCAL GOVERNMENTS AS PRUDENT PURCHASERS, AND PROVIDERS OF CARE. WHY?

      LOCAL GOVERNMENTS HAVE THE INCENTIVE TO PROVIDE QUALITY CARE IN A COST EFFECTIVE MANNER BECAUSE THEY ARE LEGALLY AND FINANCIALLY LIABLE. AS PUBLIC OFFICIALS THEY HAVE PROVEN -- AND WE HAVE MANY EXAMPLES -- THAT THEY WILL DEVELOP SUCH PROGRAMS. THEY ARE AT RISK TO MAKE UP THE DIFFERENCE IF THEY DON'T.

      LOCAL GOVERNMENTS ARE CLOSEST TO THE PEOPLE BEING SERVED. THEREFORE, THEY ARE IN THE BEST POSITION TO KNOW THE NEEDS OF THE POPULATION. THEY CAN TARGET RESOURCES EFFECTIVELY AND SPOT PROBLEMS BEFORE IT'S TOO LATE. IT WAS PALM BEACH COUNTY, FLORIDA THAT CONVINCED THE STATE AND THE FEDERAL GOVERNMENT, IN THE 1970'S THAT THEY SHOULD BE ALLOWED TO CARRY OUT A PREPAID MEDICAID PROGRAM. THE COUNTY FELT THAT BY LIMITING FREEDOM OF CHOICE, THEY COULD CONTROL THE RISING COSTS AND ASSURE ADEQUATE CARE OF

THE POOR IN PRIMARY CARE SETTINGS, RATHER THAN IN EMERGENCY ROOMS.

NATIONWIDE, COUNTIES ALSO HAVE BROAD RESPONSIBILITIES FOR COORDINATING A WIDE VARIETY OF SOCIAL SERVICE AND HEALTH PROGRAMS THAT CARE FOR THE INDIGENT. LOCAL GOVERNMENTS HAVE A TRADITIONAL AND HISTORICAL ROLE IN PUBLIC HEALTH AND CAN APPLY THEIR RESOURCES AND EXPERIENCE IN THIS AREA TO DEVELOPING BASIC HEALTH CARE PLANS FOR THE INDIGENT.

B. PROVIDE INSURANCE COVERAGE (PREFERABLY ON A PREPAID, CAPITATED BASIS), SUCH AS HMO MEMBERSHIPS FOR THE INDIGENT.

C. ALLOW FOR LOCAL GOVERNMENT OR "INTER-COUNTY COMPACTS." THESE COMPACTS WOULD PROVIDE RURAL COUNTIES WITH FUNDS TO PURCHASE CARE FROM OTHER COUNTIES WHO HAVE PROVIDERS AND NECESSARY RESOURCES.

COUNTY ROLE

FOR MANY DECADES COUNTIES HAVE PROVIDED, AND HAVE INCREASINGLY FINANCED, LAST-RESORT HEALTH CARE SERVICES TO THE POOR. EITHER THROUGH "VENDOR PAYMENTS" TO PRIVATE DOCTORS AND HOSPITALS, OR IN THEIR OWN HOSPITALS AND CLINICS. NATIONWIDE, COUNTY GOVERNMENTS ARE CHARGED BY THE STATES WITH FULFILLING THIS TRADITIONAL AND STATUTORY RESPONSIBILITY FOR FINANCING INDIGENT CARE AND FOR PROVIDING HEALTH CARE AND OTHER SOCIAL SERVICES. THE MAJORITY OF STATES HOLD COUNTIES LEGALLY LIABLE FOR INDIGENT CARE. IN STATES WITH NO SPECIFIC MANDATE, IT IS NOT UNCOMMON FOR COUNTIES TO FUND AND

ADMINISTER INDIGENT CARE PROGRAMS.

RECENT COURT DECISIONS DEMONSTRATE THAT IN MANY PARTS OF THE COUNTRY, PROVIDERS AND OTHERS TURN TO COUNTY GOVERNMENTS TO ASSUME LEGAL AND FINANCIAL RESPONSIBILITY FOR INDIGENT CARE. FOR EXAMPLE, A RECENT STATE SUPREME COURT DECISION IN NEVADA HELD WASHOE COUNTY LIABLE FOR REIMBURSING COSTS ASSOCIATED WITH CHAIRTY CARE FOR A PRIVATE NON-PROFIT HOSPITAL, REGARDLESS OF THE HOSPITAL'S FEDERAL HILL-BURTON OBLIGATION. THE COUNTY WAS CONSTRAINED BY STATE LAW FROM RAISING THE NECESSARY REVENUES, SO IT TURNED TO THE STATE LEGISLATURE, WHICH GRANTED AN EMERGENCY ALLOCATION. OTHER RECENT COURT DECISIONS HAVE ESTABLISHED THAT COUNTIES ARE "FIRST PAYORS" OF INDIGENT CARE, PRECEDING HILL-BURTON AS PAYOR.

OF THE 1,900 PUBLIC HOSPITALS IN THIS COUNTRY, OVER 900 ARE DIRECTLY AFFILIATED WITH COUNTY GOVERNMENT. PUBLIC HOSPITALS PROVIDE A HEALTH "SAFETY NET" FOR THE ELDERLY POOR WHO HAVE UNMET NEEDS, CHILDREN OF THE WORKING POOR, AND THE "NEW POOR" UNEMPLOYED WHO HAVE LOST THEIR HEALTH BENEFITS, BUT DO NOT QUALIFY FOR MEDICAID OR OTHER ASSISTANCE. COUNTIES ALSO OWN AND OPERATE OVER 600 NURSING HOMES. MANY ARE STRUGGLING TO ACCOMMODATE INCREASING NUMBERS OF ELDERLY WHO BECOME ELIGIBLE FOR MEDICAID AND ARE TRANSFERRED TO THE COUNTY FROM OTHER FACILITIES, WHERE PRIVATE PAYORS ARE MORE COMPETITIVE.

FIFTEEN HUNDRED COUNTY HEALTH DEPARTMENTS OPERATE, FUND, AND PROVIDE BASIC PUBLIC HEALTH SERVICES, HALF OF WHOM ARE THE SOLE PROVIDERS OF MATERNAL AND CHILD HEALTH SERVICES.

LOCAL REVENUES SUPPORT THE PROVISION OF COUNTY HEALTH SERVICES FOR MILLIONS OF AMERICANS WHO HAVE NO HEALTH COVERAGE. IN 1983, COUNTIES SPENT OVER 25 BILLION DOLLARS ON HEALTH CARE. THE LARGEST PUBLIC HOSPITALS PROVIDED CLOSE TO A BILLION DOLLARS IN NON-MEDICAID CHARITY CARE IN 1980. ABOUT 25 PERCENT OF THESE LARGE PUBLIC HOSPITALS ARE COUNTY-OWNED.

OVERALL, HEALTH CARE EXPENDITURES BY COUNTIES ARE ON THE INCREASE. FROM 1981-82, NATIONWIDE, COUNTY EXPENDITURES FOR HEALTH CARE WERE OVER $20 BILLION. DURING THAT YEAR, COUNTIES' HOSPITAL RELATED COSTS INCREASED 13% OVER THE PRIOR YEAR. AS THE LOCAL FISCAL SITUATION HAS TIGHTENED, THE ABILITY TO RAISE OR SHIFT REVENUES TO MEET NEEDS HAS LESSENED.

A 1982 SURVEY BY THE JOINT ECONOMIC COMMITTEE AND GOVERNMENT FINANCE OFFICERS ASSOCIATION FOUND THAT SPENDING FROM LOCAL GOVERNMENTS' OWN REVENUE SOURCES HAS CONTINUALLY INCREASED SINCE 1979. THEY DETERMINED THAT COUNTIES WERE BEARING DOWN HARDER ON THEIR OWN SOURCES TO MAKE UP FOR REDUCTIONS IN FEDERAL AND STATE FUNDS. SERIOUS CONSTRAINTS ON LOCAL GOVERNMENTS PROHIBIT THEM FROM CONTINUALLY MAKING UP THE LOSSES, HOWEVER. THESE CONSTRAINTS WILL SURELY AFFECT THEIR ABILITY TO ENSURE HEALTH CARE TO THE POOR.

TWENTY-SIX STATES IMPOSE SOME TAXING LIMITATIONS. PROPERTY TAXES, THE PRIMARY SOURCE OF LOCAL GOVERNMENT REVENUE, ARE UNPOPULAR WITH THE PUBLIC. IN EACH OF THE TWELVE YEARS THAT THE ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS (ACIR) HAS POLLED THE PUBLIC, THEY HAVE CONSISTENTLY FOUND THAT THE PROPERTY TAX IS VIEWED AS THE WORST TAX OF ALL.

BECAUSE OF RISING HEALTH CARE COSTS AND GROWING INDIGENT CARE LOADS, AS WELL AS THE TAXING CONSTRAINTS, MANY COUNTIES ARE SUPPLE-

MENTING THE LOCAL HEALTH CARE DOLLARS FROM OTHER GENERAL REVENUE SOURCES NOT PREVIOUSLY TAPPED FOR THAT PURPOSE. FOR EXAMPLE, LOS ANGELES COUNTY NOW SPENDS ITS ENTIRE GENERAL REVENUE SHARING ALLOCATION, $80 MILLION, ON HEALTH CARE.

THESE RESOURCE LIMITATIONS IN CONJUNCTION WITH A RISING TIDE OF MANDATES, LAWSUITS AND COURT RULINGS WHICH HOLD COUNTIES LEGALLY LIABLE FOR INDIGENT CARE, THREATEN THE VERY SURVIVAL OF OUR PUBLIC HEALTH SYSTEM. FURTHERMORE, WE KNOW THAT PUBLIC HOSPITALS AND NURSING HOME SALES OR CLOSURES ARE ON THE INCREASE. IN FACT, GROWING FINANCIAL PROBLEMS AND THE LIKELY PURCHASE OF PUBLIC HOSPITALS BY PROPRIETARY HEALTH CARE CHAINS PROMPTED NORTH CAROLINA'S 1983 STATE GENERAL ASSEMBLY TO TEMPORARILY STOP THE SALE OF COUNTY AND CITY HOSPITALS TO COMPANIES OWNED BY INVESTORS.

WAYNE COUNTY, MICHIGAN; CUYAHOGA COUNTY, OHIO; AND POLK COUNTY, IOWA ARE BUT A FEW OF MANY COUNTIES STRUGGLING TO KEEP THEIR HOSPITAL DOORS OPEN. ALL THREE JURISDICTIONS ARE DENSELY POPULATED, HAVE HIGH UNEMPLOYMENT AND SUBSEQUENTLY REPRESENT MANY UNINSURED PEOPLE WHOSE HEALTH CARE THEY MUST ASSIST IN PAYING FOR.

IN 1983, HENNEPIN COUNTY, MINNESOTA DETERMINED THAT THEIR MEDICALLY INDIGENT POPULATION--THOSE WHO DON'T QUALIFY FOR MEDICAID, BUT HAVE NO HEALTH INSURANCE--HAS INCREASED AND IS CLIMBING. THESE PEOPLE RECEIVE SOME MEDICAL CARE THROUGH COUNTY GENERAL ASSISTANCE, SUPPORTED BY LOCAL TAXES, AND SOME STATE DOLLARS. OTHER COUNTY STATISTICS POINT TO SHARP INCREASES IN ELIGIBLE 18-21 YEAR OLDS IN THE FEDERALLY FUNDED "MEDICAL ASSISTANCE ONLY" CHILDREN'S PROGRAM. THE COUNTY SUSPECTS THIS SHARP INCREASE IS DUE TO HIGH UNEMPLOYMENT.

ANOTHER SURVEY ON THE EFFECT OF FEDERAL/STATE LIMITS ON REIMBURSEMENT FOUND THAT OVER 30% OF THE RESPONDENTS WHO LOST COMPREHENSIVE HEALTH COVERAGE WERE DEFERRING ALL MEDICAL CARE.

IN TEXAS, WHERE UNEMPLOYMENT REACHED 10.5 PERCENT LAST YEAR, HARRIS COUNTY'S INDIGENT OUTPATIENT CARE INCREASED BY 12%. TWO-THIRDS OF THE INCREASE WAS DIRECTLY RELATED TO UNEMPLOYMENT. IN 1982, OVER TWO-THIRDS OF THE COUNTY HOSPITAL'S $150 MILLION BUDGET WAS FOR CHARITY CARE.

NEW YORK STATE HAS BEEN FORCED TO CLOSE OR SUBSTANTIALLY DECREASE MANY SERVICED PROVIDED AT IN-PATIENT MENTAL HEALTH FACILITIES. CHATAUQUA COUNTY NOTES THAT, WHILE THE STRESS OF UNEMPLOYMENT LED TO MORE REQUESTS FOR MENTAL HEALTH SERVICES, THE COUNTY AND OTHER SERVICE PROVIDERS ARE ALSO BEING INUNDATED WITH FORMER IN-PATIENTS OF STATE FACILITIES.

EXAMPLES SIMILAR TO THESE ABOUND IN COUNTIES ACROSS THE NATION. ECONOMIC RECOVERY ALONE WILL NOT STEM THE TIDE OF PUBLIC HEALTH CARE BURDENS.

COUNTY INDIGENT CARE MODELS

WE ARE FINDING COUNTIES PROVIDE A WEALTH OF INFORMATION ABOUT WAYS TO STRUCTURE DELIVERY SYSTEMS FOR INDIGENT HEALTH CARE. NACo IS DEVELOPING A SUBSTANTIVE PROFILE OF SUCH PROGRAMS THROUGHTOUT THE COUNTRY.

WE WOULD LIKE TO SHARE A FEW EXAMPLES WITH THE COMMITTEE.

TRADITIONALLY, THE FUNDING OF INDIGENT CARE IN FLORIDA HAS BEEN THE RESPONSIBILITY OF THE COUNTIES. THE COST OF INDIGENT CARE SERVICES NOT REIMBURSED BY THE COUNTIES IS USUALLY ABSORBED BY

HOSPITALS -- ESPECIALLY LARGE FACILITIES LOCATED IN URBAN AREAS. MORE COMPREHENSIVE COUNTY INITIATIVES AND SUPPORTIVE STATE POLICIES PROVIDE MODELS FOR OFFICIALS IN OTHER STATES AND LOCALITIES.

FOR OVER TWO DECADES, PALM BEACH COUNTY, FLORIDA HAS HAD AN ORGANIZED SYSTEM FOR THE PROVISION OF HEALTH SERVICES TO ITS INDIGENT POPULATION. THE COUNTY HEALTH DEPARTMENT COMBINES TRADITIONAL PUBLIC HEALTH SERVICES WITH DIAGNOSTIC SERVICES AND THE TREATMENT OF GENERAL ILLNESS TO PROVIDE COMPREHENSIVE HEALTH SERVICES TO THE INDIGENT POPULATION. THE COUNTY EMPHASIZES PREVENTIVE CARE TO REDUCE THE INCIDENCE OF MORE COSTLY ACUTE AND EMERGENCY SERVICES.

TO ASSURE PROFESSIONAL STAFF AND ADEQUATE FACILITIES, PALM BEACH COUNTY HAS DEVELOPED RESIDENCY TRAINING PROGRAMS, PARTICULARLY IN PREVENTIVE MEDICINE; HAS ESTABLISHED HEALTH CENTERS, THROUGHOUT THE RURAL AREAS OF THE COUNTY (WITH FEDERAL, STATE AND LOCAL FINANCING). THE COUNTY HAS ALSO SOUGHT THE COOPERATION OF THE PRIVATE SECTOR OF THE HEALTH CARE INDUSTRY AT ALL STAGES OF DEVELOPMENT AND IMPLEMENTATION OF INDIGENT CARE PROGRAMS.

SACRAMENTO, CALIFORNIA

CALIFORNIA COUNTIES ARE RESPONSIBLE FOR ALL INDIGENT PERSONS. SACRAMENTO COUNTY HAS IMPLEMENTED AN INNOVATIVE, READILY ACCESSIBLE, BUT CONTROLLED DELIVERY SYSTEM FOR A FULL SPECTRUM OF MEDICAL CARE. PRIMARY CARE CLINICS ARE SPREAD GEOGRAPHICALLY IN THE COUNTY AND ARE ORGANIZED TO ASSURE ACCESS TO BASIC PHYSICIAN SERVICES. ALL ADVANCED LEVELS OF CARE ARE AVAILABLE THROUGH COUNTY CASE MANAGEMENT. THE ENTIRE PROGRAM IS ORGANIZED TO MAXIMIZE AVAILABLE RESOURCES, EXPANDING ON EXISTING COUNTY PROGRAMS WHERE NECESSARY.

CONTRA COSTA COUNTY, CALIFORNIA

ANOTHER MODEL IS THE PREPAID, MANAGED HEALTH CARE PLAN IN CONTRA COSTA COUNTY, CALIFORNIA. THE COUNTY OPERATES A NETWORK OF HEALTH CLINICS AND A COUNTY HOSPITAL AND IS A MAJOR PROVIDER OF CARE TO THE COUNTY'S MEDICAID (MEDI-CAL) AND MEDICALLY INDIGENT POPULATIONS.

THE COUNTY BEGAN EXPERIMENTING WITH PREPAID APPROACHES FOR THE MEDI-CAL POPULATION IN THE EARLY 1970s. BY 1980, THE COUNTY'S PREPAID SYSTEM HAD BECOME A FEDERALLY QUALIFIED HMO, WITH A LARGE MEDICAID ENROLLMENT BUT RELATIVELY FEW MEDICALLY INDIGENT INDIVIDUALS. THE MEDICALLY INDIGENT, IN GENERAL, CONTINUED TO USE THE COUNTY DELIVERY SYSTEM ON A FEE-FOR-SERVICE BASIS.

DURING A SEVERE FINANCIAL CRUNCH IN 1982, THE STATE DROPPED MEDICALLY INDIGENT ADULTS FROM THE STATE-FUNDED MEDI-CAL PROGRAM AND RETURNED RESPONSIBILITY FOR THEM TO THE COUNTIES, TOGETHER WITH BLOCK-GRANT FUNDING APPROXIMATING 70% OF THE PRIOR YEAR'S EXPENDITURES. THE CONTRA COSTA BOARD OF SUPERVISORS DETERMINED THAT THE COUNTY WOULD CONTINUE TO MAKE SERVICES AVAILABLE TO THIS POPULATION, BUT ONLY THROUGH ENROLLMENT IN THE PREPAID CONTRA COSTA HEALTH PLAN, WITH PREMIUMS OF $125-$135 PER MEMBER MONTH PAID BY THE COUNTY TO THE HEALTH PLAN. THIS DECISION REFLECTED THE BOARD'S VIEW THAT MANAGED HEALTH CARE IN THE PREPAID PLAN WOULD BE PREFERABLE TO EPISODIC CARE SOUGHT AS NEEDED BY THE RECIPIENTS AND THAT, BY KEEPING THE RECIPIENTS HEALTHY, LONG RUN COSTS WOULD BE REDUCED. SHORT RUN COSTS PROBABLY WOULD HAVE BEEN FEWER FOR THE COUNTY IF IT HAD MERELY SUBSIDIZED THE OPERATING LOSSES DUE TO BAD DEBTS AT THE COUNTY CLINICS AND HOSPITALS.

TODAY, THE CONTRA COSTA HEALTH PLAN HAS APPROXIMATELY 13,000 ENROLLEES, OF WHOM:

4,600 ARE MEDI-CAL (MEDICAID)
500 ARE MEDICARE (ON A COST BASIS)
1,600 ARE EMPLOYER GROUPS (MOSTLY COUNTY EMPLOYEES)
AND 6,000 ARE MEDICALLY INDIGENT (CALLED BASIC ADULT CARE)

THE COUNTY DELIVERY SYSTEM STILL OPERATES ABOUT 65% FEE-FOR-SERVICE, LARGELY FROM MEDI-CAL, AND REQUIRES AN ANNUAL SUBSIDY FROM THE COUNTY (IN ADDITION TO PREPAID PREMIUMS PAID BY THE COUNTY) OF ABOUT $11 MILLION ANNUALLY. HEALTH PLAN OFFICIALS BELIEVE THIS SUBSIDY COULD BE REDUCED IF ENROLLMENT IN THE HEALTH PLAN WERE INCREASED.

MULTNOMAH COUNTY, OREGON

INNOVATIVE APPROACHES DEVELOPED IN MULTNOMAH COUNTY, OREGON, ALSO PRESENT USEFUL EXPERIENCES WITH ALTERNATIVE MODELS FOR PROVIDING HEALTH SERVICES TO THE INDIGENT POPULATION. IN 1973, MULTNOMAH COUNTY DEVELOPED PROJECT HEALTH TO ACT AS A BROKER FOR INDIGENT RESIDENTS BY NEGOTIATING PREPAID CONTRACTS WITH PRIVATE SECTOR HEALTH PLANS -- A LIMITED VOUCHER APPROACH. PROJECT HEALTH WAS DISCONTINUED IN 1983. WHILE ADVERSE SELECTION WAS A PROBLEM, PROJECT HEALTH ENDED PRIMARILY BECAUSE OF THE SEVERE RECESSION THAT SERIOUSLY AFFECTED COUNTY REVENUES. MULTNOMAH COUNTY NOW PROVIDES SERVICES TO THE MEDICALLY INDIGENT THROUGH MULTICARE -- A PRIMARY CARE NETOWRK DEVELOPED UNDER PROJECT HEALTH IN 1981. COUNTY CLINICS ARE USED AS THE ACCESS POINT FOR PRIMARY CARE AND CASE MANAGEMENT. FUNDS THAT WENT TO PROJECT HEALTH ARE NOW USED TO FUND IN-PATIENT HOSPITAL AND SPECIALTY SERVICES.

SUMMARY

WE HOPE THAT THIS INFORMATION IS HELPFUL TO YOU IN YOUR DELIBERATIONS REGARDING INDIGENT HEALTH. NACo LOOKS FORWARD TO WORKING WITH YOU ON THIS ISSUE AND OTHER HEALTH CARE ISSUES IN THE FUTURE. I WOULD BE PLEASED TO ANSWER ANY QUESTIONS AT THIS TIME.

GUILFORD COUNTY
DEPARTMENT OF PUBLIC HEALTH

MEMORANDUM

TO: Board of Health

FROM: Joe L. Holliday, M. D., Health Director JLH

DATE: September 10, 1984

RE: Need for Additional Positions in Home Health Unit
2 - PHN I, 2 - CHT, 1 - Clerk-Typist III

The Home Health Unit has been experiencing a consistent increase in referrals since late in FY 83/84 and it is continuing. As of the end of August, we have had to turn away a total of 68 patients when we had days in which we could not accept additional patients. As you know we have had, from time to time, a shortage of physical therapy services, but this is the first time we have experienced so many referrals for nursing and aide services than we could accept. The following statistics illustrate the increase in visits:

Visits	March	April	May	June	July
RN	955	833	979	1,012	1,059
H/HHA	198	349	441	454	546
All Visits	1,616	1,558	1,766	1,850	1,912

With the advent of DRGs in October, 1983, we expected a great increase in referrals from hospitals as patients were discharged earlier and therefore sicker. In December, the Moses Cone - Wesley Long Joint Venture Home Health Agency was approved. It was their intention to begin operations by April, 1984. We knew from our records that if these two hospitals diverted the increased number of referrals from us the effect would be to reduce the impact of the DRGs. So, as we were developing our plans and budgets for 1984-85 in February, we realized we faced at best, an unpredictable year. We conservatively estimated that with the new home health agencies in existence we could handle requests for services without any increase in positions. We relied on our contractual nurses to be a cushion, and we relied on aide services from the Home Health Aide/Homemaker Program, which we cosponsor with USOA.

The Joint Venture Home Health Agency did not get underway in April; they now expect to be in limited operation in December. The H/HHA Program has developed a waiting list for aide services and they have not been able to meet our increasing needs. Our agreement with the program is to assist each other in meeting requests for services. (We are currently serving 5 of their patients.)

301 North Eugene Street
P.O. Box 3508
Greensboro, N. C. 27401

At the end of FY 83/84, figures presented by H/HHA Program presented a picture that we did not need 10 full-time aides, so two positions were eliminated. We do not find we can rely on any increase for aide services during 84/85 to be met by the H/HHA Program as matters now stand.

The increase in referrals is pushing to the limit the number of visits our PHN's and Aides can make and still provide quality care. Every measure is being taken to assure that patient service is given in the most economical fashion; assigning staff to patients living in same geographical area, telephone calls made to assure patient has not been hospitalized since the last contact and thus save an unnecessary visit, reducing the number of supervisory visits (PHN to Aide) to non-medicare patients when situation is such that it is safe to do so. We are making fewer visits than the patients need - i.e. 2 times per week instead of 3 times per week.

Our two team leaders who have major responsibility for patient assignments, working with 10 full-time PHN's, 7 contractual nurses, 1 Occupational Therapist, 4 Physical Therapists, 2 Speech Therapists, taking referrals from M.D.s, medical centers, etc. also make home visits to the extent they can in order not to turn patients away. Last FY they made 657 visits. They need to be relieved of making visits and be full-time managers.

It is my recommendation that these positions be added in order to maintain services at the current level of requests and to provide some relief for our staff. The Clerk-Typist position is needed to provide management support services for medical records, physicians' orders and billing.

The addition of 2 nurses, 2 aides and 1 clerk will bring our staff to a level to meet current patient requests. As noted on the attachment, these positions can be funded through additional medicaid/medicare revenue. Should the trend continue, we will need to consider additional requests later this year.

JLH/cb

Attachment

CC: John V. Witherspoon
J. D. Rowland
Karl Munson
County Commissioners

Expenditures

2 - PHN I	
Salary and fringes	$20,665.00
Travel	1,000.00
	21,665.00
	x 2
	$43,330.00
2 - CHT	
Salary and fringes	$13,019.00
Travel	1,000.00
	14,019.00
	x 2
	$28,038.00
1 - Clerk-Typist III	
Salary and fringes	$13,290.00
	$84,658.00

Revenue

2,015 nursing visits to be made
1,329 or 66% reimbursed at medicare rate of $45.00 = $ 59,845.50

1,776 aide visits to be made
1,456 or 82% reimbursed at medicare rate of $28.33 = $ 41,248.48

$101,093.98

GUILFORD COUNTY
DEPARTMENT OF PUBLIC HEALTH

September 18, 1984

Charles C. Riddle, Sr., Executive Director
United Way
305 N. Main St.
High Point, N.C. 27260

Dear Mr. Riddle:

Within the last six months, the demand for in-home health services by our elderly citizens, expecially those with fixed or limited incomes, has greatly increased. The Guilford County Board of Health is attempting to meet the health needs of our elderly but the Board would also strongly encourage the United Way to be more responsive to our elderly citizens with chronic illnesses.

You are probably aware that our local nursing home beds are full with waiting lists. Last year's fiscal changes in the medicare program have resulted in patients being sent home from our local hospitals much earlier than ever before. At home recuperating, these patients also require a more intense level of home health services than before. In the last six months, requests for all types of home health services has escalated greatly. For example, our home health aides made 546 visits in July, 1984 as compared to 198 visits in March, 1984.

In anticipation of this trend, the Department of Public Health assisted a United Way Agency, United Services for Older Adults, in establishing a central pool of Homemaker/Home Health Aides that could grow to meet this need. USOA has successfully started such a program, established a needed training program for aides and attracted federal and foundation funding.

At present, families, physicians and patients are requesting home health services that exceed our community's capacity to provide these services. Both the Department of Public Health and USOA have waiting lists for Homemaker/Home Health Aide services. Our local "for profit" providers are now turning away patients who cannot afford their services with greater frequency.

The Guilford County Board of Health plans to seek a significant addition of five home health staff in the immediate future. Should the trend continue, the capacity of this additional staff will soon be

301 North Eugene Street
P.O. Box 3508
Greensboro, N. C. 27401

exceeded-especially that of the Homemaker/Home Health Aides. The Board of Health would hope that the United Way would recognize this increasing community-wide problem and be equally responsive to our elderly's needs. Could not some additional funding be given to USOA for this purpose?

Sincerely,
Gene Grubb
Gene Grubb, DDS, Chairman
Guilford County Board of Health

GG/lbm

September 21, 1984

Board of County Commissioners
Greensboro, N.C. 27401

Dear Ladies and Gentlemen of the Commission:

We wish to encourage your favorable consideration of the need for funding the requested additional staff positions of the Home Health Services of Guilford County (Department of Public Health).

We were made aware of the increasing needs of the community at the recent meeting of the Advisory Board for Home Health Services. As representatives of the community we agreed that this need should be addressed and we encourage your awareness and positive action.

Respectfully Yours,
J. E. McDowell
J. E. McDowell, President
Home Health Advisory Board

cc: John V. Witherspoon
Dr. Gene Grubb

DAVID AXELROD, M.D., COMMISSIONER OF HEALTH, STATE OF NEW YORK DEPARTMENT OF HEALTH, ALBANY, NY

Dr. AXELROD. Thank you, Mr. Chairman.

You have already heard about New York State's pooling arrangement for the provision of funds for dealing with the problems of uncompensated care. As you are all aware, New York State is one of four States which has received a waiver of Federal regulations in order to include the Federal Medicare Program in its all-payor hospital reimbursement system. I am going to focus only on one major component of our system. This is the experience that we have had with the New York prospective hospital reimbursement methodology to date in New York State.

In 1983, hospital costs in New York increased by approximately 8.2 percent compared to a nationwide increase of 12.3 percent. Also, the average Medicare per-patient payment in the State increased by 5.29 percent, compared to a nationwide increase of 9.5 percent.

In 1983, the New York prespective hospital reimbursement methodology saved Medicare approximately $153 million; all-payors would have spent a total of $400 million more if costs in the State increased at the national rate.

However, successful cost-containment programs in New York precede the implementation of the existing waiver which occurred in 1983. Based on data from HCFA, it now appears that during the period from 1976 to 1985 New York State will have saved the Medicare Program over $11 billion.

NYPHRM—the New York Prospective Hospital Reimbursement Methodology—has kept the doors of New York's health care institutions open for the most vulnerable of our citizens.

Why have I focused upon the savings that have occurred, the ability of New York State to keep the increase of health care costs down? I have focused upon it because it provides the ability to incorporate mechanisms for dealing with the problems of bad debt and charity care, uncompensated care, within the available funds that have been allocated, assuming a reasonable rate of inflation.

NYPHRM recognizes the need to support hospitals that provide essentially free care to our most vulnerable citizens. This is a particularly critical problem in major urban centers due to the high proportion of individuals living at poverty or near-poverty levels. In many cases the hospitals provide the only medical care available to the population. Last year the State's nonpublic hospitals provided over $325 million of care to those who could not pay.

One of the reimbursement methodology's two mechanisms for financing health care for the medically indigent is the bad debt and charity pool. Each third-party payor of health services increases its payment rate by a specified percentage. These amounts become part of a regional funding pool, and they are distributed to hospitals based upon each hospital's need. In 1983, the pool equalled $160 million; in 1984, it will equal approximately $250 million; and in 1985, approximately $360 million.

In addition, during 1983 and 1984, approximately $44 million will be available on a regional basis to assist financially distressed hospitals that are experiencing severe fiscal hardships due their extraordinary bad-debt and charity loads. The purposes of these funds is to avert a crisis which may threaten an institution's fiscal liability and to jeopardize a community's access to health care. Any unused funds are added to the bad-debt and charity-care pools for uniform distribution.

Within the legislation that created the Federal system, Congress included a provision aimed at encouraging States' all-payor programs in order to provide a safety net as we experiment with a new national system and as a way to measure the success of the system. It appears that the Health Care Financing Administration has not shared completely our view that the development of State all-payor systems should be encouraged. HCFA has not yet issued final regulations, which are due by October 1, and there are questions about whether HCFA intends to judge the effectiveness of our State system in a manner consistent with the statutory intent.

Since we have successfully contained the growth of hospital care costs at the same time that we are providing support for the health care of the economically disadvantaged, we hope that Congress recognizes the importance of having the option to continue our system, and that the administration's action concerning the granting of Medicare waivers is closely monitored by the Congress.

The chart behind me is one which demonstrates the actual expenditures in New York State and projected expenditures from 1975 through 1985 and what otherwise would have occurred in the absence of New York State's cost containment program.

Thank you, Mr. Chairman.

Senator DURENBERGER. Thank you very much, Doctor.

[Dr. Axelrod's written testimony follows:]

Statement of David Axelrod, M.D.
Commissioner of Health
State of New York

Testimony Presented to the
Committee on Finance
Subcommittee on Health
United States Senate

On Health Care for the Economically
Disadvantaged

September 28, 1984

I am grateful for the opportunity to present New York State's experience in providing health care for the economically disadvantaged. New York is one of the four states which has received a waiver of federal regulations in order to include the federal Medicare program in its all-payor hospital reimbursement system.

Today I would like to focus in some detail on two of the components of our State system that specifically address the financing of health care for the economically disadvantaged -- the bad debt and charity care allowance and the special allowance for financially distressed institutions.

I would also like to describe why we think our system clearly addresses the concerns of Congress when it chose to encourage state all-payor reimbursement programs at the same time that the new federal system was being implemented.

Let me begin by providing you with a brief overview of the New York Prospective Hospital Reimbursement Methodology [NYPHRM]. First and foremost, our system is a success:

- it has contained the rise in hospital care costs more effectively than the new federal Prospective Payment System (PPS) - in 1983 hospital costs in New York State increased by 8.2 percent, compared to a nationwide increase of 12.3 percent; also, the average Medicare per patient payment in New York State increased by 5.29 percent, compared to a nationwide increase of 9.5 percent;

- it has saved the Medicare trust fund literally hundreds of millions of dollars - in 1983 alone, this savings amounted to $153 million dollars; all payors would have spent a total of $400 million dollars more if costs in the State increased at the national rate. However, successful cost containment programs in New York precede the implementation of the Prospective Hospital Reimbursement Methodology in 1983. Based on data from the Health Care Financing Administration, it now appears that during the period from 1976 to 1985, New York State will have saved the Medicare program over $11 billion dollars. (See Table Attached);

- it has kept the doors of our health care institutions open for the most vulnerable of our citizens.

Because of this record, we think that our system can provide valuable information to you as you examine how to reach our mutual goal of ensuring access to quality health care to all - including those low income persons, ineligible for Medicaid, who are falling through the cracks of our health care delivery system.

We began our unique three year hospital in-patient financing experiment on January 1, 1983. It is predicated on the assumption that there are not endless resources to invest in health care -- and therefore, those dollars that are available should be allocated prudently and with an eye toward priority services. The three primary goals of the system are:

- to maintain expenditure growth in the system at reasonable levels -- for example, inflation -- through a uniform, prospective methodology;
- to achieve a stable and predictable revenue base for hospitals; and,
- to reinvest those funds that would otherwise have been spent in a less controlled environment, to help meet the costs of treating the uninsured -- and to allocate those funds to facilities most in need.

New York's reimbursement system recognizes the need to support hospitals that provide essentially free care to our most vunerable citizens. The growing cost of health care has removed medical care from the reach of millions of Americans. There are a number of neighborhoods in the cities of New York State that are characterized by a poor economy, poor housing, a system that does not foster economic upward mobility, chronic illness and high infant mortality rates. These are frequently the neighborhoods with significant medically indigent populations. These areas are not particularly attractive places to live and work and few doctors are interested in practicing in them.

In many cases, the hospitals in these areas provide the only medical care available to this population. They have taken it upon themselves to serve their communities regardless of the ability of the residents to pay--incurring deficits as a result and pushing some hospitals to the brink of bankruptcy. Providing support for these facilities takes on an even greater importance, if we view the hospitals as major community organizations which provide not only health care, but supportive services and employment.

Traditionally, hospitals were able to cover the costs of charity care and bad debts by seeking philanthropic support and by shifting costs to patients covered by the commercial insurance carriers. However, most hospitals in the inner-city receive little philanthropic support and patients covered by commercial health insurance plans usually seek care elsewhere. Recognizing the haphazard nature of this situation, our State reimbursement program has come to the support of these institutions through a more equitable allowance for bad debt and charity care. This allowance has kept many needy hospitals financially solvent and has enabled the continued provision of care to the economically disadvantaged. This is a particularly critical problem in major urban centers due to the high proportion of individuals living at poverty level or near-poverty levels. Last year, New York's non-public hospitals were able to provide over $325 million dollars of care to those who could not pay. We have done this while still keeping the increases in payments to hospitals from government health programs and insurance plans well below the national average. We can only continue to afford financing this care, if the cost growth of hospital care is maintained at this current low level.

The mechanism for distributing funds for bad debt and charity care is simple. Each third party payor of health care services increases its payment rate by a specific percentage. These amounts become part of regional funding pools and are distributed to hospitals based on each hospital's need. There are discrete pools for public hospitals and for voluntary nonprofit and proprietary facilities. A hospital's eligibility for funds is dependent upon its making a reasonable effort to obtain payment from those it serves and the ongoing provision of services to patients unable to pay.

In 1983, total statewide resources available to finance bad debt and charity care equalled 2% of total statewide reimburseable costs or $160 million. In 1984, the pool equals 3% or approximately $250 million and in 1985, the pool will equal 4% or approximately $360 million.

Of the $160 million available in 1983, major public hospitals received approximately 19% of this amount or $30 million. This amount was, based on the ratio of such hospitals' reimbursable inpatient costs to total statewide reimbursable costs. The remaining $130 million was distributed through regional pools to aid voluntary and proprietary hospitals based on specific need to achieve a uniform level of support. Voluntary and proprietary hospitals eligible for this relief received approximately $.39 cents for each dollar spent on bad debt and charity care. In 1984, we anticipate that the voluntary and proprietary hospitals eligible for this support will receive $.62 cents for each dollar spent on bad debt and charity care. In 1985, we estimate that they will receive $.85 cents on the dollar. In absolute dollar terms, this means that those facilities which provide the bulk of the free care will receive the bulk of support.

In addition to the allowance for bad debt and charity care, New York State's reimbursement methodology also includes a special allowance for financially distressed hospitals. During 1983 and 1984, approximately $44 million dollars, will be available for distribution on a regional basis to assist facilities experiencing severe fiscal hardship due to their extraordinary bad debt and charity care loads. The purpose of these funds is to avert a crisis which may threaten an institution's fiscal viability and jeopardize the community's access to health care. The funds can be awarded, based on specific criteria, to specific facilities which qualify for them. If unused or partially used, the remainder is added to bad debt and charity pools for uniform distribution. It is clearly a major factor in our State's efforts to provide needed health care to the economically disadvantaged.

Allowances for bad debt and charity care and for financially distressed institutions clearly address concerns expressed by Congress when it enacted legislation to promote state alternatives to the national reimbursement system. Although the current federal Medicare reimbursement system is a great improvement over the retrospective payment system Medicare used in the past, it still raises many unanswered questions.

One of the concerns raised about the new federal reimbursement system was whether it would bring the cost savings and basic changes in medical care that its supporters claimed it would. In many ways, the future of the Medicare trust fund is dependent on the cost savings the system is intended to accomplish. Every American has an interest in the success of the new system, but there is still as yet no sound evidence that these goals will be accomplished. In the event that our expectations about the new federal system are not realized, concepts derived from New York State's experience, could be quickly employed to modify the federal system.

Another concern raised was whether the national program would bring about cost savings in every state. Like all national programs, the new reimbursement formula must rely on common denominators and generalities. The new system works well in some states, but in others it may be unable to accomplish its goals. It may overpay hospitals in some states and underpay and create severe financial hardships for hospitals in other states.

A third major concern was whether the new reimbursement system would bring about cost shifting and higher health insurance premiums. A reimbursement system that controls only the payments of one health care program may promote cost shifting and may do little to control total health care costs. Cost shifting is simply a means of charging some patients more to cover the loss of revenues from other patients. It allows hospitals to ignore the cost control program of a single health care program and to avoid the more difficult task of containing costs. But cost shifting also has a more sinister effect. It threatens one of the most basic benefits of the American worker -- health insurance coverage. Cost shifting means an increase in employee health insurance premiums. As experience has shown us, increases in premiums force many businesses to eliminate or to reduce health insurance coverage for their employees. Obviously, this can potentially lead to an increase in the number of economically disadvantaged people in need of health care, with no means of paying for it. New York's system avoids the potential cost shifting problem by including all payors in the reimbursement methodology.

A fourth major concern was whether the new reimbursement system would threaten the very existence of those hospitals that serve the economically disadvantaged. Few banks and other financial investors consider inner-city hospitals and other facilities that serve the economically disadvantaged as sound investments. Since a large number of patients are unable to pay, the hospital's financial solvency is always questionable. Because of this lack of financial support, these hospitals are often unable to make needed renovations and modernization efforts that would enable them to function as efficiently as a more prosperous hospital would. As a result of the new federal reimbursement system, these hospitals will be at an even greater disadvantage since the system shortly will not recognize hospital specific costs, and will ultimately establish a uniform price for each diagnosis. This problem is a cyclical one since as a facility deteriorates, persons with a payment source will tend to use more modern and efficient facilities, while the economically disadvantaged will be forced to continue to utilize the deteriorating facility. The financial solvency of the hospital will only deteriorate further.

Therefore, faced with the untested and untried reimbursement program that could spawn cost shifting and other problems, Congress chose to encourage state all-payor reimbursement systems. In many ways, Congress looked upon the state systems as a safety net as we experimented with a new national reimbursement system, and as a way to measure the success of the new system. As part of the legislation that created the federal Prospective Payment System, Congress explicitly added a provision aimed at encouraging state programs. This section of law, Section 1886(c) of the Social Security Act, sets forth the explicit conditions and requirements for Medicare's participation in a state system. Congress also enacted special provisions for the four states that had already implemented all-payor reimbursement systems.

Although Congress intended that states have the option of developing all-payor state reimbursement systems, the Health Care Financing Administration (HCFA) apparently does not share this view.

Congress had intended that HCFA issue the final regulations governing state all-payor systems by October 1, 1984. HCFA has yet to propose regulations and there is little evidence that these regulations will be forthcoming in the near future.

Congress explicitly established standards by which HCFA is to judge the effectiveness of state all-payor reimbursement systems and to recoup monies if necessary. However, in draft regulations now circulating, HCFA has developed its own standards, which we believe are contrary to the statute.

In Section 1886(c) of the Social Security Act, Congress required the Secretary to judge the effect of such state systems and recoup funds if necessary on the basis of the rate of increase in the cost of hospital services in that state as compared to the national rate of increase. The law further explicitly provides that states have the option of having this test applied on the basis of aggregate payments or payments per discharge.

HCFA, in reviewing New York State's proposal for determining the effectiveness of our system, argues that Congress did not really want the states to have this option. Instead, HCFA argues that Congress really wanted the Secretary to choose whether to apply this test on the basis of aggregate payments or payments per discharge.

We believe that it is not appropriate for HCFA to make an abitrary decision to judge the effectiveness of our reimbursement system in whatever way suits their purpose. In our view, such a decision represents an effort to ignore the desire of Congress to assure that alternative reimbursement methodologies continue to be tested and refined.

Although not a panacea, New York's Prospective Hospital Reimbursement Methodology offers significant advantages. Most hospitals will receive added income, and the industry as a whole will benefit from increased fiscal stability and predictability of revenues. Our system has successfully controlled the rate of increase of hospital costs, it has promoted equity among payors and has strengthened the financial situation of facilities close to bankruptcy as a result of uncollectable debt and charity care. Many states are currently unable to meet their obligations to support health care for the economically disadvantaged--the New York system allows us to do this while successfully controlling cost increases.

I should also note, that although our reimbursement methodology is, at this point, only responsive to the bad debt and charity care problems of hospitals, New York State has recently taken one additional step. We have provided a direct State appropriation of $2.5 million dollars for the provision of health care to the medically indigent in neighborhood primary care centers.

In order to continue our successful all-payor prospective reimbursement system and to continue to meet our obligations to support health care for the economically disadvantaged, we wish to to assure that the option to seek an extension of our Medicare waiver is available when the current one expires on January 1, 1986 -- if it is in the best interest of the State, all of the payors, and our system of hospital care to do so. We hope that you continue to support the need for further testing of reimbursement methodolgies and that you closely monitor the Administration's actions concerning the granting of Medicare waivers.

We are pleased to be able to contribute to your efforts to determine how best to ensure access to health care for all and hope that you will agree that the New York State reimbursement system has made major steps to finance health care for those who are "falling through the cracks" of our health care delivery system. Thank you.

Senator DURENBERGER. I try to keep these questions minimal since we've got a number of other panels and a variety of other questions in writing; but first, Dr. Axelrod, I wonder if you would help me understand just a little bit more about the way in which the third-party payors are charged on their rates for the bad-debt pool and the charity-care pool—or maybe it's one pool.

As we all know, there are certain experiments going on around the country. I think Dorothy referred to the Florida situation in which they are using a slightly different way to tax health care for health care premiums to provide for the poor. I would argue with your conclusion on the bottom of page 9, that the Congress intended that the States have the option of developing all-payor State reimbursement systems. To the extent that I am a part of this Congress, there are not going to be any more all-payor systems in this country, if I can help it. And HCFA is absolutely right.

Now, someplace in between the good that New York is accomplishing, with something that looks somewhat like an all-payor kind of an arrangement with some regulation on the spreading of the cost, and what some of the other people are experimenting with around the country, I suppose is the future of the waivers. And we have to be very sympathetic with what New York has been able to accomplish with a very difficult and complex set of obligations. But at least New York got out ahead of it a long time ago and is trying to wrestle with it.

But just so I understand how the New York system of financing part of that health care for the medically indigent operates, tell me a little bit about how the State assesses those rates on payors.

Dr. AXELROD. The major payors, including the major private and public payors, for whom rates are determined by the State, involved in the all-payor system, paid an additional 2 percent in 1983, 3 percent in 1984, and will pay 4 percent in 1985 for the bad-debt and charity-care pools, as part of the revenues paid directly to the institutions. What that means, for example, is that commercial payors for whom charges are set by the institutions will have that additional add-on put into it by the institutions themselves. There is a maximum differential also, so that the differential between the so-called Blue Cross rates as opposed to the commercial rates are limited to 15 percent.

Senator DURENBERGER. Take me through that one again.

Dr. AXELROD. OK.

Medicare, Medicaid, and the voluntary payors paid an additional 2 percent in 1983, 3 percent in 1984, and will pay 4 percent in 1985, as part of the rates paid to the institutions. For commercial payors, the institutions currently have a charge-based system; but the differential between Blue Cross and the charge cannot exceed 15 percent total. So that in determining the charges for those commercial payors, the institutions are treated similarly as those in the all-payor system, over which we have direct control of the cost of the bad-debt and charity-care pool, which is 2 to 4 percent over the 3 years of the waiver that we currently have in effect. Bad debt and charity care are combined.

To deal with the problem of collection, there is a requirement that there be a maintenance of effort, and we do audit the institutions to make certain that there is not a major shift from what is described as "bad debt" to "charity care" over the course of the waiver period. So there is a single pool which covers both elements but in which there is independent auditing to assure the maintenance of effort for collection of bad debts.

Senator **Durenberger**. How do you enforce the fee, or whatever we are calling this, on the payors?

Dr. **Axelrod**. It is in the rates that are calculated directly in the payments to the hospitals. We determine under statute the rates for all the payors. So when we calculate the rates to be paid to the institutions, it includes the sums that are allocated for the bad debt and charity care, as well as the several other pools that have been incorporated into the rate system under the waiver in New York State.

Senator **Durenberger**. So does that mean that I can't do Medicare business in the State of New York without paying—what is it?—4 percent this year for your bad debt?

Dr. **Axelrod**. Three percent this year. Yes; that is correct.

Senator **Durenberger**. And has HCFA acknowledged that that is appropriate, that the Medicare trust fund be charged 3 percent of these costs to take care of bad debt in New York hospitals?

Dr. **Axelrod**. Yes.

Senator **Durenberger**. That's part of your waiver arrangement?

Dr. **Axelrod**. Yes, sir.

Senator **Durenberger**. Very interesting.

I'd rather have it happen in New York than in Boston, but I still am a little uncomfortable.

Dr. **Axelrod**. Well, I think there are special considerations. If one looks at, as I tried to point out, the overall rate of increase in New York State, there have been major benefits to the Medicare fund over the course of the last 10 years. Some of those benefits have resulted in major problems, with respect to the provision of care within inner city hospitals that are experiencing the greatest difficulties with the bad-debt and charity-care issues. So in discussions with HCFA on the waiver, that was a major consideration. It was not something that HCFA offered to do without a great deal of discussion.

There was another major element, and I think that it needs to be acknowledged with respect to the uniqueness of New York State, at least on the east coast, and that is the number of illegal immigrants who are in New York State. The number of illegal aliens for whom health care is being provided in the public facilities as well as in some of the voluntary facilities, is enormous. And there was an acknowledgement on the part of the Federal Government that it bore some responsibility for those costs, for bad-debt and in this case charity care that were being provided by the institutions as well.

Senator **Durenberger**. But the only point with regard to these hearings is that workers in America are being charged 1.45 percent of their earnings—and it is going up every year—into a Medicare trust fund that is going broke, so that the Federal Government can discharge its responsibility for illegal aliens, or whatever. That is the point of this hearing, I guess. And I'm really glad that you add that dimension, because clearly what we are doing here, through this waiver as an example, is we are sort of indirectly discharging some other Federal obligation through the Medicare trust fund, as are other people.

Now, I am not arguing that it should or shouldn't be done. Probably in New York, given a variety of the condition and given the accuracy of the chart behind you, maybe that's not a bad way to go. But before you came in, in my opening statement, I dealt principally with the purpose, or one of the purposes, of this set of hearings, which is to identify what it is we are doing so that we can deal with it in a more explicit fashion. And I guess you would have to acknowledge that to the degree that a system like New York's—even though it seems to save money—continues to use Medicare and Blue Cross and a lot of other systems to finance the bad debt of hospitals, to finance the care for the poor, to finance for refugees, and so forth, it prevents us at least to some degree from dealing a little more specifically and explicitly with how best can those people be cared for in this system.

There is an admission that the existing system works just fine, so "let's just continue to send the bill for it to the third-party payors."

Dr. **Axelrod**. If I may, Mr. Chairman, I think that that is precisely the intent of the waivers that are granted to the States. I think there are ways to utilize the waivers to address precisely the kinds of questions that you have raised. We are in fact evaluating the way in which the waiver has dealt with the whole of the health care system in precisely the context that you have defined it. I think that we are going to seek major changes in the way in which our waiver is structured, because I'm not sure that it has addressed adequately some of the other questions that relate to the way in which health care is to be delivered to all segments of our population, whether it be in New York State or elsewhere.

But again, it only tends to emphasize the importance of having other options to evaluate the kinds of pressures that can be brought on the health care system to be more responsive, rather than to simply have a single PPS system.

Senator **Durenberger**. Yes. And that's why I think the New York system is a good one, because we won't even start getting into graduate medical education today. But if we don't deal in the larger sense with that kind of a problem, you know, we can't expect New York to be able to change a lot of the way that it is doing it, other than in an incremental sense.

But I do think the State is a good example of the problems we have created for ourselves in this country, with this variety of cross subsidies just to keep the system going.

Dorothy, you mentioned that 55 percent of the money spent on indigent care is drawn directly from the county taxes, or property taxes, I guess.

Ms. **Kearns**. The $10 million that I speak of actually is from the property tax. The $1.5 million is from the Department of Social Services. That is their match for Medicaid.

Senator **Durenberger**. Rick, we haven't come back and visited for several years the whole issue of State pooling arrangements, and you mention it in your statement. I sort of have the impression that they looked like a great thing in about 1979–80 when they first came up. I know Connecticut had one, and Minnesota had one, and maybe there were a couple of others. What has happened to them since then?

Mr. Curtis. Well, I'm hardly an expert in this area. I think, first of all, the point has to be made that by and large those pooling mechanisms do not really improve access for the poor. They do improve access for uninsurable individuals who have preexisting conditions, and so forth. But the way they are normally structured, people have to pay a premium that the poor could not afford, even with the pooling mechanism.

As I mentioned in the testimony, the ERISA exemption of self-insured entities, which Hawaii has gotten around through specific explicit exemption language in Federal law, really severely limits the potential of this approach at the State level because of the extent to which employers are moving to self-insurance.

A related example of that problem—I understand in Florida, when they were looking at revenue sources for the medically indigent, they originally were thinking of some sort of a tax assessment on insurance. But in Florida, as in many other States, an increasing number and a large number currently of private sector employers are self-insured, and that meant they would have been exempt, and it would have created all sorts of market problems and inequities. So instead they looked at an assessment on the hospital sector.

Now, in fact, they are not now using those revenues to set up the indigent fund pool they originally envisioned in hospitals, because as a first step they used the funding to establish a medically needy program—they did not have one in Florida—to shore up the State match needed for that.

So as a result, what we have there is a funding source coming from the hospitals and all-payors of hospital services being funneled back into a broader set of services through a Medicaid/medically needy program. In my view it is a sensible approach, but a more sensible approach would be an assessment on all payors, representing a more comprehensive package of services.

Senator Durenberger. Well, can I ask that question of all three of you? My access to the health care system is financed through my work, in effect, the tax on my wage. The elderly's access is financed through my work also, and for a couple of years in their lifetime through theirs. But when we get to the poor, we come back and tax my admission to the hospital, or my purchase of a health insurance premium. Why do we do that? Why don't we finance the access of the poor into the hospital and doctor system by taxing me in my general revenue sense? Why is it that it's my admission to the hospital that has to be used? Why can't we spread it so that all people in the country help to take care of the poor, not just sick people? What is the rationale for that?

Mr. Curtis. Let me start by saying of course Medicaid, State and local, general assistance programs, and so forth, are by and large supported with general fund revenues through Federal, State, or local.

Senator Durenberger. Right.

Mr. Curtis. And those are the largest programs.

I think it's arguable that, looking at the substantial expansions of State and local general fund based revenue sources, not only has the problems I outlined in terms of volatility, but in addition, as you well know, in many States there are popular referendums that constrain the rate of growth in public sector revenues. Those constraints, I believe, at least, are more severe than you are going to see as a rate of increase in the health care sector even through effective regulation in New York or through an effective functioning market in Porter, MN. I think that the preference through the marketplace or through regulation of the American people, because of improvements in technology, increasing elderly population, and so forth, is going to be that the rate of increase that is acceptable in the health care sector is substantially larger than the rate of increase that the American public will allow in the way of revenues to State and local government. If that is the case, then it seems to me very sensible to look at financing sources that are directly tied to those judgments about what is acceptable in the way of an increase in the health care sector. It will also help to avoid artificial constraints on the rate of increase in the health care costs overall, based upon what State or local government has for their welfare programs, which is what you are going to get back to.

Senator **Durenberger**. But, you know, I represent 29 million people and a payment mechanism under those 29 million people that is on the verge of bankruptcy. Now, how are you in the individual States going to force me to pay a premium for the poor out of that bankrupt trust fund? How are you going to manage that?

There is one way you can do it—you can go this route right here, and say that, you know, we're going to freeze in place all of the hospitals, and we are going to have all-payor systems, and all that sort of thing. And then the elderly in New York or Massachusetts, or some other place, will be deprived of a place to go because I won't pay the "poor premium." You know, then they scream, and D'Amato and Moynihan then get on my back, and then we cave in, or something like that. [Laughter.]

But why are we going to make the elderly and all of the working people pay for these systems?

Mr. **Curtis**. OK. I should clarify. I was trying to describe the advantage of the Florida approach. When it comes to the applicability and appropriateness of using Medicare trust fund dollars, I will leave that to an exchange between you and Dr. Axelrod.

Senator **Durenberger**. Maybe Dr. Axelrod will respond.

Dr. **Axelrod**. Well, certainly I would agree that however you look at it the tax base is going to provide for it, whether it comes out of the Medicare trust fund or whether it comes out of taxes on employees' health plans, or however else it is structured.

The one thing that occurs with respect to using the system we have is that we provide a stability and predictability with respect to the amount of money that is going to be available, that is indexed to the actual cost of delivery of health care, not to some artificial indices that are set to limit the cost of growth for one segment of our population; that there is an equity issue with respect to the availability of health care to all of the citizens, not necessarily one who the other portion of our citizens. And one way of providing for that equity is to key it to the actual expenditure rate that is occurring in the rest of the health economy rather than simply for that which is identified as being a group that somehow is a ne'er-do-well population who cannot afford or should not be afforded the availability of health care or access to the same degree that those other insured populations are.

Senator **Durenberger**. But, Doctor, what I can't understand is why you don't put a tax on restaurant meals and food in the grocery stores to explicitly pay for food stamps in New York; or, why don't you put the property tax, a premium on the property tax, on homes in New York that will go into subsidizing housing for poor people in New York? Why is it only in the health care area that people who get sick have to pay for the poor that get sick? What is the logic in that?

Dr. **Axelrod**. I think that there are several issues. I think that the first is, of course, that the health care is considered somewhat differently from almost any other element, whether it be food or whether it be housing or any other part of our social program. I think there are differences, and that while we are prepared to accept certain inequities with respect to availability of housing and with respect to the availability of foods, I don't think that our population is prepared to expect inequities with respect to the availability of health care. And I think that it is true that eventually, if you have an individual identifiable allocation that is independent of what otherwise is occurring within the health care system, you will certainly move to a situation in which health care is going to be geared to some independent parameter that has nothing necessarily to do with access to quality health care, which I think is what we all are trying to obtain.

Senator **Durenberger**. Well, we are running out of time. This is not a dead horse, it is a very live horse, so I don't want to beat it anymore. And I don't think the proposition here is that of diametric opposites. I just hope that as we go along through this process we recognize the weakness of politicians to address these problems. You know, it is so much easier to stick with the old system, in which you hide the poor in my Blue Cross plan, than it is to go and raise the taxes, because, just as you said, nobody wants "their taxes" raised. Elliot Richardson sure knows that. Nobody wants their taxes raised. [Laughter.]

So the better thing is "pretend the problem doesn't exist." And my problem is that that's what is responsible for the $350–360 billion a year in health care costs in this country, because in New York I can't play much of a role in holding down those hospital costs because I just don't get rewarded in any way—I have to rely on Dr. Axelrod and the system to hold down the annual increases in there, and they are being pushed by the poor, and they are being pushed by the teaching hospitals, and they are being pushed by the new liver transplants. And I can't get any reward in that New York system, I guess, for getting in there and making some better choices.

But I still like it better than what I see in some of the other parts of the country. So, given the problems that you have in New York——

Dr. **Axelrod**. Well, I think if you give us an opportunity to continue our waiver, we will provide you with some other options. [Laughter.]

Senator **Durenberger**. That was the interesting comment that you made, that maybe that waiver can be structured or restructured in some way to give us the value of how you can go after some of those other subsidies.

Dr. **Axelrod**. With your help. [Laughter.]

Senator **Durenberger**. All right, thank you all very much. We appreciate it.

Ms. **Kearns**. Can I say one thing to you?

Senator **Durenberger**. Of course.

Ms. **Kearns**. I agree with you as a public official in your comments about how we go about this. And I read a little statement somewhere about public education that said, "How do we treat this difficult issue?" And it said, "You attack it on all fronts at once." And I think this shared responsibility is our answer to that.

Senator **Durenberger**. Got it.

Thank you very much.

Our next panel consists of Michael D. Bromberg, executive director of the Federation of American Hospitals; Robert B. Johnson, executive director, District of Columbia General Hospital, accompanied by Sharon Hildebrandt, director of the State Issues Forum, on behalf of the AHA; Ray Newman, chairman of the board and chief operating officer of the Dallas County Hospital District, on behalf of the National Association of Public Hospitals; Dr. Bob Heyssel, president of Johns Hopkins, and John Cooper, president of the Association of American Medical Colleges; and Judith A. Ryan, executive director of the American Nurses' Association.

Let me say that I appreciate all of you being here today and your advance texts, all of which will be made a part of the record.

Apparently these lights have been working on a 3-minute system. As you notice, if you go over a little bit you don't get penalized.

The questions are so lengthy and so numerous in this area that I am going to have to submit them to all of you in writing. So maybe if you need to take 5 minutes and make a decent opening statement, then feel free to do that.

I guess we start in the order you were introduced, with Mr. Bromberg.

[The questions follow:]

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, WASHINGTON, DC

Mr. **Bromberg**. Thank you, Mr. Chairman. I want to join with some of the others in commending you for having these hearings. I have been at several meetings in the last couple of months where this issue has come up, and people have asked the question, "Does anyone in Washington care?" And the mere fact that you are having this hearing I think is going to hold out some hope.

Our organization has adopted a resolution recently clarifying our position on this issue and stating that we believe it is a national priority to develop public policy in this area, particularly because price competition is making it clear that we can no longer solve this problem through a hidden tax or a cross subsidy as we have been doing historically. Historically it has been done through either higher charges and not telling patients what they were really for, or public hospitals, hopefully adequately funded at the State and local level, were solving most of the problems.

Price competition is changing all that, and in terms of our industry, we're somewhere between $4 and $5 million of a total that is over $6 billion in terms of uncompensated care.

Public hospitals obviously are providing three and four times the amount of uncompensated care, if not more than that, than private nonprofit as well as private for-profit hospitals.

We believe a broad tax revenue base is necessary to finance this problem and that there is a proper Federal role. Unemployed and uninsured workers in Detroit 2 years ago, for example, could not be asked to look to their county or State government alone for adequate financing; there are geographic variations which make this a national problem.

Ideally, we would urge you to consider a Federal block grant to provide funds for the States based on their economic needs. The Federal budget deficit may make that unlikely; however, we still think it is a priority issue, and perhaps other Federal block grant programs could be expanded to cover indigent care.

Since such a high percentage of the cases are related to maternity, broadening block grants in that area might be a way to start along that path.

Since the Federal income tax law subsidizes employer purchased insurance with no limit, a tax-free fringe benefit which primarily helps the middle class, a cap on this benefit could provide new Federal revenues for such a block grant program.

In our testimony we quote from the President's Ethics Commission report chaired by Morris Abrams, I think a quote which really I won't read now but it does sum up the ethical. I noticed in your opening comments you mentioned there are moral issues here, and they did raise the moral and ethical issue of how we can give more than a $30 billion subsidy to the middle and upper-middle class, more than twice what we spend on Medicaid, and not give anything directly to the people who fall between the cracks. I really think it is a moral issue.

I want to talk briefly about the States. Several States, in fact more than a dozen we think, are presently seriously considering options for dealing with indigent care. One is to increase Medicaid eligibility or add a medically needy benefit which obviously would attract Federal matching money. Other options include property tax earmarking, alcohol, tobacco taxes, or excise taxes on private insurance.

I do want to comment on the Florida situation, because we believe that this is kind of a sick tax, a Robin Hood tax, and a much too limited group to be an equitably broad-based tax which would meet what we think is society's responsibility and not one part of it.

Two comments on testimony from a prior witness, very briefly before I close. One is that the 2-percent add-on in New York, from the point of view of hospitals, really comes out of the pie. In other words, if hospitals wind up with a 5-percent price increase, they don't really look at it as the payors are paying 2 percent; they look at it as they would have gotten 7 and they are only getting 5—similar to what is happening in Florida in terms of a Robin Hood approach.

And second, when I hear talk about waivers benefiting illegal aliens in New York, I can't quarrel with that; but I do wonder about what about the illegal aliens in California and Texas? In other words, every time we grant a waiver it has an impact on a State other than that, as I think you covered.

In conclusion, we do commend you for holding these hearings, and the only other point we would make—and I think you are going to do this in your third set of hearings—is that we do think there are many ways in which to deliver the care once the revenue is raised. We have concentrated on the revenue. And there are cost-effective ways to do this, using competitive health plans, but that really those options should remain at the State level, but more of the funding should come from the Federal level.

Thank you, Mr. Chairman.

Senator **Durenberger**. Thank you.

Mr. Johnson?

[Mr. Bromberg's written testimony follows:]

STATEMENT OF

MICHAEL D. BROMBERG
EXECUTIVE DIRECTOR
FEDERATION OF AMERICAN HOSPITALS

BEFORE THE

HEALTH SUBCOMMITTEE
OF THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

ON THE
DELIVERY OF HEALTH CARE TO THE ECONOMICALLY DISADVANTAGED

SEPTEMBER 28, 1984

The Federation of American Hospitals is the national association of investor-owned hospitals and health care systems representing over 1,100 hospitals with over 135,000 beds. Our member management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

The Federation of American Hospitals believes it should be a national priority to develop an effective public policy to finance and deliver health services to those who are unable to pay for their health care and who are uncovered by existing government or adequate private insurance programs. This issue is increasing in importance as the health system becomes more price competitive due to pressures from business, insurers and government to reduce costs.

More than ten percent of the population lacks government or employer sponsored health care insurance. Historically, services to indigent patients have been subsidized by private patients as part of charges or have been provided at public hospitals where part of the operating funds were funded from state and local taxes.

Our health care delivery system is undergoing a revolution. The revolution, moving from a cost based to a price based system is causing a change almost overnight in the way hospitals do business. Purchasers of health care also play a significant role in this revolution by now demanding more cost effective and efficient care.

Price competition has made it difficult for private hospitals to continue cross-subsidizing indigent care. Private payers, employers and business coalitions have mounted increasing resistance to paying for uncompensated care through this cross-subsidy. The total uncompensated care burden on community hospitals exceeds $6 billion. The investor-owned sector of the hospital industry assumes over $400 million of that total, representing over four percent of revenues, approximately the same percentage as non-profit, non-public hospitals.

Data indicates that more than 50 percent of indigent patients are hospitalized for maternity or accident cases and that about two-thirds of the costs are in low technology and lower than average cost admissions.

The basic public policy question is whose responsibility is it to finance this needed care? We believe government has a proper role as provider of last resort for the poor. The public hospital has historically filled that role as an arm of government but adequate funding is not being appropriated and more efficient delivery of care must be assured. The tax revenue to finance indigent care should be broadly based because society as a whole should meet its responsibility to care for the disadvantaged.

There is a proper federal role in financing indigent care based on the geographic variations in numbers of disadvantaged individuals. Unemployed and uninsured workers in Detroit in 1982, for example, could not look to their city or state alone for adequate financing.

Ideally, we would urge a federal block grant program to provide funds to the states based on their economic needs. While the federal budget deficit makes such a new program unlikely, this is a priority issue and perhaps other federal grant programs could be expanded to cover indigent care. Since such a high percentage of indigent cases are related to maternity care, broadening the maternal and child health program could be a logical start.

Since the federal income tax law subsidizes employer purchased health insurance without limit, a tax-free fringe benefit which primarily helps the middle class, a cap on this benefit could provide new federal revenues for an indigent care grant program.

The President's Commission for the Study of Ethical Problems in Medicine has published a volume on "Securing Access to Health Care," which provides some sound advice on how government should establish its priorities in health expenditures.

With reference to the tax-free treatment of employerpurchased health insurance to employees, the Commission noted:

> "The employer-exclusion provision gives a large subsidy to those with a small need for financial protection and exacerbates the tendency of lower-income people to be less well insured than those

with higher incomes." The Commission goes on to say, "This pattern of care is difficult to justify from an ethical standpoint. There seems to be little reason for such government assistance to middle and upper-income individuals, most of whom could take financial responsibility for their own care...without undue hardship."

We heartily endorse this position and believe that on fairness grounds alone the tax cap should be applied forthwith.

The tax subsidy, now estimated at over $30 billion, represents substantially more than the federal government spends on Medicaid.

Several states are considering options for financing indigent care. One option is to increase Medicaid eligibility or add a medically needy benefit. This option attracts federal matching funds. Another option is to generate new state revenues through alcohol, tobacco or property taxes, or an excise tax on private health insurance plans. Florida recently passed a tax on hospital net revenues; however, we believe this type of tax on a limited provider group is not an equitable way to meet a societal responsibility. We believe the source of financing should be much broader-based, from all the people in the nation or all the citizens of a particular state to assure adequate funding and a sharing of the responsibility.

The delivery of care to indigents, however financed, should assure quality and cost effectiveness. In order to avoid creation of a new entitlement program with open-ended budgetary impact, we believe state or local governments should be responsible for administration or purchasing of services. Options should include direct contract negotiations with providers for a fixed fee or capitation rates and use of alternative delivery systems such as health maintenance organizations (HMOs), preferred provider organizations, and case management programs, as well as direct subsidies to state insurance pools and other institutions with high indigent care populations. Other items certainly can be added to this list.

In conclusion, we strongly support the current evolution of the health care system towards competition based on price and quality. However, to foster this environment we must make solving the indigent care problem a national priority; it must be financed in the broadest way, preferably at the federal level or next at the state level; and these programs should be administered locally with incentives for efficiency by use of competitive delivery systems.

STATEMENT OF ROBERT B. JOHNSON, EXECUTIVE DIRECTOR, DISTRICT OF COLUMBIA GENERAL HOSPITAL, ACCOMPANIED BY SHARON L. HILDEBRANDT ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. JOHNSON. Good morning, Mr. Chairman.

Senator DURENBERGER. Good morning to you.

Mr. JOHNSON. Thank you very much for the opportunity to appear before the committee. I will try to give you a focus from my perspective as the administrator of a public hospital here in Washington and to try to give you some sense of the experience that we have in providing health care to a large indigent population.

D.C. General Hospital is a 500-bed teaching hospital that is affiliated with Howard and Georgetown Universities. We are the only public acute-care hospital in Washington, DC. Last year we provided some 120,000 outpatient visits and about 85,000 emergency room visits. We are the largest provider of ambulatory care in the Washington metropolitan area. We provide primary, secondary, and some tertiary care services to the population we serve. In fiscal year 1984 we were operating on an $89 million operating budget; the sources of revenue—approximately 26 percent from medicaid, 11 percent from Medicare, 10 percent from Blue Cross, commercial, and other sources, and 53 percent from tax-supported local dollars from the District of Columbia government for medical and nonmedical services.

It is clear that the problem of indigency is not an urban problem alone. Though there are many rural Americans who suffer from lack of access to health care, lack of access to care is largely an urban problem because of the concentration of large numbers of poor in urban centers.

The patients we see are sicker, they seek care later in the disease process. It has been pointed out in a study by the Urban Institute that in 1980 $7.5 billion worth of care was provided to the poor primarily in the 100 largest cities. It is not surprising that a large portion of that care is provided by public hospitals. Some 37 percent of the care was provided by public hospitals, even though they only represented some 13 percent of the hospitals in the study.

D.C. General Hospital alone provides some $35 million worth of uncompensated care each year, in a city where all the other 12 hospitals collectively provide $70 million of uncompensated care.

Public hospitals that I represent and that serve the poor find that their survival is threatened. We are threatened principally because of the mission we have, and that is to serve the residents of our communities regardless of their ability to pay. And even though we take a great deal of pride in that and believe that that is our reason for being, the ability to sustain that commitment is threatened because of the circumstances that we find ourselves in. We serve the homeless, we serve illegal aliens, we serve refugees, we serve a large number of people simply who cannot pay, that are both working and nonworking individuals. We experience a large number of transfers to our institutions, simply because of financial reasons. In the last 2 years we have had an over 400-percent increase in the number of patients transferred to our hospital solely for financial reasons. We don't call it dumping, because we believe that that is our role—that is, we are here because the District government and this community has said that it ought to provide care to those D.C. residents who cannot pay. But it is obvious that as we increasingly provide more care to those who cannot pay, on a tax base that is limited, we will find it difficult to sustain the level of quality that we believe is appropriate.

We say that public hospitals are especially impacted by a number of things that have occurred in the last 10 years: the combined effects of the national and local governments' control of health care costs; the development of an intensively competitive environment in which hospitals that have traditional missions of serving the poor as well as others are increasingly reducing their commitment because of financial considerations; the increased number of the poor and near-poor who are located in urban areas; and the demand for high quality care as well as high technologically acceptable care.

I would say that public hospitals in general are faced with three competing needs. Public hospitals need to have financial arrangements made that ensure their ability to survive as well as encourage other hospitals to provide needed health care services. We need programs that address the facilities in which we provide that care, and we need to have sufficient flexibility to adapt to changing circumstances.

Very briefly, we have been developing within the last 9 months an experiment with the District government that will become effective next week, where they will begin to pay us for indigent care on a cost-per-care basis much like Medicare and Medicaid in this city provides care. It also will differentiate that $35 million subsidy, which is now up to $43 million this year and will go to $44 million next year. It will distinguish the nonmedical service we provide to the D.C. government agencies, and it will pay us for what we lose under the below-cost reimbursement from Medicare and Medicaid. It is cost-shifting from the Federal to the local government.

We also are currently studying ways of developing an HMO for Medicaid patients. We believe that it is our responsibility to be creative and try to find ways of solving our own problems, recognizing that they cannot be solved solely by local initiatives.

We also believe that there needs to be ways of expanding the way indigent care is provided, whether it is at the Federal or local level. We believe that all payors have a responsibility to help pay for indigent care, whether it is the State government or whether it is third-party payors. And has clearly been pointed out in the discussions before, indigent care is a societal problem. There is clearly a need to have the broadest base of tax support to assist those who cannot pay for their health care.

Finally, hospitals like D.C. General, a facility that was built some 47 years ago and designed 57 years ago, must ultimately be replaced and must have financial support that would allow us to maintain an acceptable physical plant.

And finally, we must have some degree of administrative freedom, which is a local problem, to ensure that we can change to meet the changing times, can address problems in a constructive and creative way, and be given relief from burdensome local regulations that are simply inimical to operating as a hospital.

Thank you very much for the opportunity to make a statement, and I have submitted my formal statement for the record.

Senator **Durenberger**. Right. And it will be made a part of the record. Thank you.

Mr. Newman?

[Mr. Johnson's written testimony follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
TO THE SUBCOMMITTEE ON HEALTH
OF THE
SENATE COMMITTEE ON FINANCE
ON
HEALTH CARE FOR THE ECONOMICALLY DISADVANTAGED

September 28, 1984

SUMMARY

The District of Columbia General Hospital, the only public acute care hospital in Washington, D.C., is a 500 bed teaching hospital affiliated with Howard and Georgetown Universities, and provides a range of primary, secondary, and some tertiary services. Over $35 million in uncompensated care is provided anually to residents of the District of Columbia by the hospital. Most of our budget comes from a subsidy provided by D.C. taxpayers.

D.C. General Hospital, as other public hospitals, is an endangered species. We are threatened by our mission, which is to serve all patients regardless of their ability to pay. We are further jeopardized because we treat more seriously ill patients and are bound by local government rules. Moreover, the combined effects of national and local government efforts to control health care costs and reduce outlays, the development of a competitive health care environment, and the growing indigent population impair the level and ability of public hospitals such as ours to sustain their historical commitment to the poor while remaining financially viable.

Our ability to sustain a viable financial base is dependent on continued support from the D.C. government, efforts to reduce our costs, and developing alternative financing and delivery systems. The preservation and strengthening of D.C. General is crucial to the delivery of high-quality health care to the District's urban poor. The responsibility for health care delivery to the poor is the sole province or responsiblity of neither public hospitals nor the government.

STATEMENT

My name is Robert B. Johnson. I am the Executive Director of the District of Columbia (D.C.) General Hospital, where I have served for the past eight and one-half years. I am pleased to have this opportunity to appear before this subcommittee because I feel strongly that the preservation and strengthening of the public hospital is crucial to the delivery of high-quality health care to the urban poor in this city and in many other cities around the country. I also believe that the responsibility for delivery of health care to the poor is neither the sole province or responsibility of neither public hospitals nor the government.

The issue of health care for the poor is receiving increased attention and recognition as the most fundamental health care issue facing us today. Health care for the poor is not solely an urban problem. There are millions of rural Americans for whom access to and the ability to pay for health care is a serious daily problem. However, it is an undeniable fact of urban living in the United States today that the poor are disproportionately concentrated in our large urban centers.

A study by the Urban Institute documented that in fiscal 1980, short-term general non-federal, non-profit hospitals in the nation's 100 largest cities provided care to the poor--bad debt, charity care, and Medicaid--worth $7.5 billion. Almost two-thirds of the total volume of care to the poor went to Medicaid recipients. Public hospitals play a disproportionately large role in serving the poor. While public hospitals constituted 13.3 percent of all institutions surveyed by the Urban Institute and contained about 14 percent of the beds, they supplied 37.2 percent of all care to the poor.

This is not surprising or particularly unexpected. The principal mission and responsibility of public hospitals is to serve the poor. D.C. General Hospital, the only public acute care hospital in Washington, D.C., provides over $35 million annually in uncompensated care to D.C. residents. This in spite of the fact that the other 12 acute care hospitals in Washington provide over $70 million in uncompensated care annually. Most of this care is provided to District residents, but not all.

I would like to provide you with some background information about D.C. General Hospital. We have a 500 bed hospital, with 57 bassinets. D.C. General is a teaching hospital affiliated with Howard and Georgetown Universities and provides a range of primary, secondary, and some tertiary care services. We handle about 120,000 outpatient visits and 85,000 emergency room visits each year. Our Fiscal Year 1984 budget was $89 million, of which 50 percent is from a direct tax subsidy for the medical and non-medical services we provide. Eleven percent of our patients are Medicare; 26 percent are Medicaid, and 10 percent are Blue Cross, commercially insured, and others. Over the past 10 years, D.C. General Hospital has made the transition from a troubled institution to one that is accredited, better organized and managed, provides high-quality care, and is on a solid planning and financial footing. However, lest I lead you to believe that we do not have serious problems, let me quickly point out that we, like most public hospitals around the country, are a threatened and endangered species.

- We are threatened by our mission: to serve all patients regardless of their ability to pay. This translates into a patient population made up of transfers from other hospitals, the homeless, refugees, illegal aliens, and other special populations historically not served by our elaborate health care system.

- Public hospitals are further jeopardized because we treat more seriously ill patients: patients with multiple diagnoses and those who are victims of infectious diseases, accidents, violence, and substance abuse. A high proportion of our patients over-utilizes emergency rooms.

- We are bound by local government rules for salaries, revenues, purchase of goods and services, residency requirements, borrowing for capital financing, and building facilities.

In spite of these factors, D.C. General Hospital has:

- regained accreditation from the Joint Commission on Accreditation of Hospitals;
- been reorganized under the D.C. General Hospital Commission as an independent agency;

- developed a modern administrative organization and attracted many well-qualified medical and administrative personnel;

- initiated a $25-million capital construction project to correct long-standing life safety code violations;

- developed our first long-range plan in 1979 and a five-year plan this year;

- developed a number of clinical programs designed to meet the special needs of our patients, such as trauma care, geriatric care, and adolescent medicine; and

- significantly increased the amount of third-party collections.

Unlike many other public hospitals, we operate in a local political environment that is generally supportive of a public hospital. However, to understand the problems that we and other public hospitals face in our efforts to survive and continue to provide high-quality care, you need only examine four major trends.

In the past 10 years, public hospitals have witnessed: 1) the combined effects of national and local governments' efforts to control health care costs and reduce their outlays for health care; 2) the development of an intensely competitive environment in which health care is delivered; 3) the increase in the size of the poor and near-poor population and their continuing urbanization; and, finally, 4) the demand for high-quality and high-technology care.

When you combine these environmental, social, and political indicators, you have a situation in which the government wants to pay less for health care for the poor. Many urban public hospitals, such as D.C. General, depend on government for over 90 percent of their revenues. Cost shifting affects public hospitals; however, the shift is not from Medicaid and Medicare to Blue Cross, commercial insurers, and self-pay patients: it is from the federal to the local government. The ability of private hospitals to sustain their historical commitment to the poor is rapidly eroding. With the advent of fixed-rate payment and discounted care, many private non-profit hospitals simply do not have the financial capacity to offset large amounts of charity and bad debt care, as they formerly could. And as most hospitals compete for patients and physicians, there is little room in their mission statements for community service.

Contrary to political rhetoric, the number of people below the poverty line is growing. However, the fiscal reality that most Americans face is that few are able to pay for medical care out of their own pockets. It is estimated that nearly 35 million Americans have no health care insurance. D.C. General Hospital has attempted to be faithful to its primary mission, which is to provide care to any D.C. resident regardless of ability to pay. In the past two years we have seen a 400-percent increase in transfers to D.C. General Hospital from other D.C. hospitals, primarily for financial reasons. We recognize and accept the responsibility for the care of D.C. residents who cannot pay. However, because of the need to ensure the orderly transfer and safe transport of patients, the Commission and medical staff adopted a transfer policy last fall. This policy says:

- that care to D.C. residents unable to pay is our responsibility,
- that we accept only emergency room to emergency room transfers of D.C. residents who can be safely transferred and for whom prior arrangements are made,
- that we will not accept transfers of hospitalized patients if the transfers are due only to the patients' lack of health insurance, and
- that appropriate medical records must accompany the patient.

Despite the progress made at D.C. General in the past seven years since it was reorganized under the Commission, we face three serious problems that will affect our ability to survive as a viable institution providing high-quality care. These problems can be classified as financial, facilities, and flexibility.

The development of prospective payment systems for Medicare and Medicaid and the continuing restriction on payments from all third-party payers has led us to develop a new payment methodology with the District Government. It would subsidize our hospital for non-medical services we provide to other D.C. Government agencies and permit us to bill the District government, on a cost-per-case basis, specifically for indigent care. The goal of the subsidy and prospective payment for all patient services permits more accountability for the services we provide on behalf of the D.C. government, yet recognizes the District's obligation to adequately compensate the hospital for the costs associated with care we provide to D.C. residents unable to pay.

In addition, D.C. General Hospital was the first hospital in the District of Columbia to come under the Medicare DRG Prospective Payment System in October 1983. During the first year's experience with the DRG system, we have fared reasonably well. In fact, we will end the year September 30, 1984, with Medicare payments of $12.5 million, compared to costs of $11.8 million. The three principal reasons for this occurrence are: an increase in the hospital's case mix, an increase in Medicare admissions, and a reduction in our average length of stay. However, we project that when a single national Medicare payment rate is implemented in FY 1987, we will be losing $2 million annually. This will happen because the first year under Medicare prospective payment relies heavily on hospital-specific costs, but by the fourth year, hospital-specific prices will be eliminated and a national rate will be in place for all hospitals.

Our ability to remain financially viable under those pressures will depend on continued support from the D.C. government, continued efforts by the hospital to reduce costs without sacrificing quality, increasing the number of patients we serve, and developing innovative means of financing and delivering health care.

Our second problem is one of facilities. D.C. General Hospital is housed in a facility that was designed 57 years ago and built 47 years ago. Many other public hospitals are housed in similar aging and obsolete buildings. The hospital's facilities are a jumble of poorly designed multiple buildings, spread over an excessively large campus, expensive to operate and maintain, and in no way meeting present or future demands for modern health care technology. Faced with loss of reimbursement from Medicare and Medicaid and having lost then regained accreditation, the District of Columbia has had to invest over $25 million in the current plant just to meet life safety code requirements. After several years of seeking funds to build a new ambulatory care/critical care facility, we were budgeted $14 million to build this facility beginning this fall. But due to fiscal uncertainties and a reexamination of the District's priorities, the fate of this project is now in question. It is my contention that if D.C. General Hospital is to remain a viable acute care hospital serving the city's poor, a new hospital must be built.

Finally, like all hospitals faced with enormous changes in the way health care is organized, financed, and delivered, we must have the operational flexibility realized by private institutions. This means corporate authority to operate as any other hospital. Over the past four years we have been pursuing, albeit unsuccessfully, additional financial, personnel, and capital construction contracting authority. The hospital's long-range plan suggests the need to move toward a more flexible model of governance and management, thus enabling D.C. General to compete in the marketplace.

The future of D.C. General and other public hospitals depends on our ability to operate as a broad-based community resource, providing not only inpatient services but arranging for preventive care and health education programs, coordinating health and welfare services with other human service agencies, and developing an organized system of ambulatory primary care services to ensure access to care.

D.C. General Hospital is at the crossroad with future progress at one hand and potential stagnation at the other. In this era of rapid and profound changes, status quo is, in fact, retrogression. The health care needs of the patients in the community we serve demand that we remain a viable institution. Therefore, we must serve not only as providers of care, but also as strong advocates for the patients we serve and the institution through which we meet their needs.

STATEMENT OF RAY G. NEWMAN, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER OF THE DALLAS COUNTY HOSPITAL DISTRICT, DALLAS, TX, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, ACCOMPANIED BY LARRY S. GAGE

Mr. NEWMAN. Thank you, Mr. Chairman.

I am chairman of the board of the National Association of Public Hospitals and accompanied today by Larry Gage, who is president and general counsel of NAPH. I think also the fact that Bob Johnson is here representing the American Hospital Association lends substantial weight to the common problem that we feel uncompensated care is. Mr. Johnson also happens to be the next chairman of NAPH, following me.

The testimony we have submitted includes some things from revealing data about where the uncompensated patients are receiving care, and it includes some substantial information about who is providing that.

One of the questions we wanted to respond to was where there services are being received by the disadvantaged economic patients, and the substantial majority of these are in hospitals that are classified as public hospitals, because they exist for those patients and they provide a wide range of services that are otherwise not available in many cases in the private sector. Specialty care units such as burn centers, trauma centers, neonatology, child abuse centers—these often are too expensive for the private sector to provide, and they often are unprofitable; so many of these are available only in public hospitals, when they are available.

How are these services financed? Largely by local support that already exists for the public hospitals. The NAPH membership—31 percent of those hospitals' support comes from the local community, compared to 22 percent from Medicaid and 14 percent from Medicare. On the average, public hospitals have only about 12 percent of private patient population to which they have been able to shift costs.

We are concerned about safeguarding the access to this care for the Nation's poor, because sooner or later these public hospitals are also going to be providing more and more services to the elderly as they become disenfranchised because of the regulatory reforms that have taken place.

Recent Urban Institute data shows that 40 percent of charity care in the Nation is delivered by 5 percent of the hospitals, and these are the public hospitals. Five percent of the beds provide 40 percent of the charity care. Nonprofit hospitals provide 22 percent of the charity care, and they represent 26 percent of the beds. Proprietary hospitals—one-tenth of 1 percent of charity care is provided by them.

Of the large city public hospitals, according to Urban Institute data, 50 percent of those hospitals have total deficit margins as compared to 20 percent from the nonprofit or the private sector. So the publics have 2½ times the number of deficits as the private sector, and where those deficits occur they are six times higher than the deficits in the private sector.

Several public hospitals have closed around the country in large cities, and others are converting their structure to become private hospitals. This is in the face of the reforms that have taken place and the increased competitive pressures that exist.

The public hospitals are not only absorbing their reductions in reimbursement, but they are also being compounded by absorbing reductions in cost by other hospitals that are transferring out of necessity.

The new data that are presented are fully explained, and we also have some specific data from the Texas situation a State has that has over 500 hospitals and where the Medicaid program covers only 25 percent of the people below the Federal poverty guidelines.

One of the pieces of data that you will see: in 1981, five public hospitals alone provided 30 percent more care in charity services than the entire State Medicaid Program did for all 500 hospitals.

The Texas Hospital Association estimated last year that there was 1.6 billion dollars worth of uncompensated services. NAPH data reflect that 30 percent of that total comes from just five hospitals—that's 1 percent of the total hospitals.

We are concerned about running hospitals as a business, public hospitals especially, but it is not just business that we are in the business of. Publics are not on a level playing field to content with the competitive pressures that are there. We believe in it; however, it is not level, and it is not on an equitable basis.

Parenthetically, one of our local public hospital administrators came to the conclusion that the world is not flat nor is it round, it's funnel-shaped. And his hospital is at the end of the funnel.

We would encourage you to insist that the provision that is already in the regulation, which requires HHS to provide allowance for the hospitals providing services to a disproportionate share of low-income and Medicare patients, be acted upon because it is in existence now. There has been no action taken on it.

Thank you.

Senator **Durenberger**. Thank you very much.

Dr. Heyssel?

[Mr. Newman's written testimony follows:]

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS 1503 Twenty-First Street, N.W., Washington, D.C. 20036 (202) 861-0434

STATEMENT OF RAY G. NEWMAN
Executive Vice President and
Chief Operating Officer
Dallas County Hospital District

Subcommittee on Health
Committee on Finance
United States Senate
September 28, 1984

Mr. Chairman, members of the Subcommittee, I am Ray Newman, Executive Vice President and Chief Operating Officer of the Dallas County Hospital District in Dallas, Texas. The District owns and operates Parkland Memorial Hospital, an 832 bed major public teaching hospital. I also serve as Chairman of the Board of Directors of the National Association of Public Hospitals, and I am accompanied this morning by Larry S. Gage, President and General Counsel of that organization. NAPH consists of 50 public hospitals and hospital systems which serve as major referral centers and hospitals of last resort for the poor in most of our Nation's largest metropolitan areas. Finally, Parkland is a Charter Member of the Texas Association of Public Hospitals, which was founded last year to address public hospital concerns at the state and local levels.

Denver General Hospital
Boston City Hospital
District of Columbia General Hospital
Harris County Hospital District (Houston)
University of Medicine and Dentistry of New Jersey Hospital (Newark)
Grady Memorial Hospital (Atlanta)
Cleveland Metropolitan General Hospital
Santa Clara Valley Medical Center (San Jose)
Glades General Hospital (Belle Glade, Florida)
The Los Angeles County Hospitals
Parkland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
San Francisco General Hospital
Bellevue Hospital Center
Bronx Municipal Hospital
Cook County Hospital
Contra Costa County Health Services Department
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
Chope Community Hospital (San Mateo)
Worcester City Hospital
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Complex
Nassau County Medical Center
Regional Medical Center of Memphis
Pacific Medical Center (Seattle)
University of New Mexico Hospital
Harborview Medical Center University of Washington
Fresno County Valley Medical Center
Wayne County General Hospital
General Hospital Ventura County
R.E. Thomason General Hospital (El Paso)
Kern Medical Center (Bakersfield)
University of Cincinnati Hospital
University of Texas Medical Branch
Queens Hospital Center
Hurley Medical Center (Flint)
San Bernardino County Medical Center
San Joaquin General Hospital (Stockton)
Southern Nevada General Hospital (Las Vegas)
Riverside General Hospital University Medical Center
University of Oregon Health Sciences Center
Spartanburg General Hospital (Spartanburg, SC)
Harlem Hospital Center
Charity Hospital of Louisiana
Maricopa Medical Center (Phoenix)
St. Louis County Hospital
Memorial Medical Center (Savannah, GA)

We appreciate the opportunity to participate in these hearings today, and we are particularly grateful that your Subcommittee has singled out the topic of uncompensated care for a series of oversight hearings this year. NAPH was founded nearly four years ago with the problem of uncompensated care as its number one long range priority, and virtually every action we have undertaken in that period has had the goal of achieving and financing access to high quality care for all of our Nation's citizens, regardless of their ability to pay or the nature or severity of their illness.

Your increased attention to this problem today is essential, because substantial changes in public and private reimbursement systems -- ranging from the Medicare prospective payment system to the growth of HMOs, PPOs, and other alternative delivery systems -- have significantly increased the pressure on hospitals serving disproportionate numbers of patients unable to pay for their care.

The expressed purpose of your hearing today is to "determine what services the economically disadvantaged are now provided, how those services are provided, and how they are financed." We feel uniquely well qualified to provide the committee with information on this subject, because in most of our Nation's largest metropolitan areas, a substantial majority of "uncompensated" inpatient and hospital outpatient services are provided by public hospitals and clinics operated by cities, counties, hospital districts, and state university teaching facilities.

We have provided this Committee with considerable information in the past about the nature and financing of services in such facilities. We welcome this opportunity today to summarize our response to your primary questions, provide you with an update of our previous submissions regarding the situation and experiences of public hospitals nationally and in Texas, and discuss in greater detail the impact of various implemented and proposed regulatory and financing changes on our hospitals and the patients they serve.

I. Introduction and Overview

At the outset, I would like to summarize our direct response to the primary questions you have raised for this hearing:

B. WHAT SERVICES ARE NOW PROVIDED TO THE ECONOMICALLY DISADVANTAGED, AND HOW ARE THOSE SERVICES DELIVERED?

Our answer to this primary question has two parts:

First, we would remind you that in order to measure the full scope of the need for services by this population, it is also necessary to take into account necessary health services which are not being received. Earlier this year, the Robert Wood Johnson Foundation issued a report with the disturbing conclusion that fully twelve percent of the United States population have trouble receiving medical care when they need it. That report also found that uninsured individuals are three times more likely to do without needed care for financial reasons than those with insurance, and that uninsured persons report no regular source of medical care, generally have no idea how to seek regular care, and are far more likely to put off necessary care, particularly in the first year following loss of insurance.

Second, it is clear from recent data gathered by NAPH, the Urban Institute and others that when services are received by this population, the substantial majority of such services are provided by public hospitals and clinics, particularly in our nation's larger metropolitan areas, with a smaller, but also significant, level of services also provided by a handful of private non profit metropolitan area hospitals. Fortunately, the nature and quality of the services received by uninsured patients in such institutions remains high, due to the teaching status and wide variety of inpatient and outpatient services available. While most of these services are provided on an ad-hoc, "open door" basis, state and local governments are also experimenting with alternative delivery mechanisms, such as capitation and primary care case management.

B. HOW ARE THESE SERVICES FINANCED?

While a certain level of services has traditionally been financed through cost shifting mechanisms in the private sector, the vast majority of non-Medicaid services for the uninsured poor have been financed through direct appropriations by cities, counties and (to a lesser extent) states. NAPH member budgets alone were over $6.2 billion last year, and 31% of those budgets on average are financed through local tax dollars -- property taxes, sales taxes, and other extremely regressive forms of taxation. While one recent study (by Vanderbilt University) estimated total "uncompensated" hospital care at $6.2 billion nationally, that study failed to include a substantial proportion of such direct local subsidies. The Urban Institute's recent estimate appears closer to the mark: $9.5 billion was spent on hospital care for uninsured patients in 1982 from direct local and state non-Medicaid appropriations, and another $3.2 billion was recorded that year in the private sector as bad debt or charity care.

Other than through Medicaid, and a very few current demonstration projects such as Arizona's "ACCCHS" program and several grants to individual hospitals, the federal government simply does not participate directly in the financing of "uncompensated" hospital care. Nor is there any indication that such participation will increase in the future. If anything, with a very few minor exceptions, the prospects for such participation (through direct grants, Medicaid expansion or demonstrations, waiver or other new programs) seem more remote than ever before. Yet it is the federal government, not states or localities, that has the most equitable taxing and re-distributive mechanisms available. Nor can we realistically look to hospitals in the private sector to increase -- let alone maintain -- their level of commitment to providing "uncompensated care", given the tremendous other economic and environmental pressures at work in our health system today.

As a result of these trends, it should come as no surprise to you that the commitment -- particularly of local governments -- to continue to maintain and finance a high level and quality of services, and explore improvements in the delivery of those services, is by no means infinite. In the face of the increased subsidization often required to respond to present economic and health system "reforms", and the increasing unwillingness of the federal government to participate financially in current or creative new delivery systems, more of our nation's essential public hospitals may soon follow the thirteen large city hospitals which have closed since 1970, or the others which have been sold or converted. If attention is not paid to these concerns we believe these trends could lead to a genuine catastrophe for our nation's health system, for our uninsured and underinsured citizens, and ultimately, for our very social order.

At the very least, all major participants in our nation's health policy debate must come, sooner or later, to the realization that the kinds of competitive and other health system reforms considered so desirable today would be virtually impossible in the absence of this institutional health "safety net".

The remainder of my testimony will be divided into three parts, which will provide more detailed data and information in support of this general response:

In Part II, I will seek to bring the Committee up-to-date on the current situation of public hospitals nationally, including new data comparing the fiscal, demographic and health services delivery situation of metropolitan area public hospitals with other types of hospitals.

In Part III, I will review for you the current situation with regard to public hospitals in the State of Texas, and with regard to Dallas County in particular. In that regard, I will pay particular attention to the delivery of health services to low income persons in a state with an extremely inadequate Medicaid program, including the impact on that system of the growing trends in the health industry toward prospective payment, competition, entrepreneurialism, and the "bottom line" fiscal mentality in health care delivery and financing.

In Part IV, I will summarize new information regarding the impact on public hospitals of several regulatory and financial amendments and reforms which have recently been adopted or proposed, including the Medicare and Medicaid program changes. In that regard, I recognize that it is not your intention to discuss potential future reforms in this hearing. However, we believe you must be aware of the impact on our Nation's "safety net" hospitals of the many different reforms already underway or proposed in our Nation's health system.

II. The Situation of Public Hospitals in America Today

A. General Overview

NAPH has described our nation's public hospital system in considerable detail in previous testimony before this Committee. However, we have not appeared before this

Committee in several months. I therefore believe it is appropriate in the context of this hearing to describe again in some detail several key service delivery and financing elements common to America's "safety net" hospitals, and direct your attention to a number of new studies which shed further light on the role and situation of public hospitals in our nation today.

This Nation has repeatedly considered enacting National Health Insurance and it may yet be possible for us to design "solutions" for the problem of uncompensated care which permits all of our Nation's citizens access to every doctor and every hospital in our system. Until that time, however, we must acknowledge that there presently exists a nationwide network of institutions, the Nation's public, and a handful of metropolitan area private hospitals, that provide and finance many of the services needed by uninsured individuals, and therefore in effect serve as a less costly surrogate. We believe the federal government must take steps to protect and preserve that network.

With regard to specific data in support of this general observation, NAPH has conducted several new surveys in the last several months to augment the information we have provided to this Committee in the past. We have also begun an intensive analysis of data collected by other researchers, such as the Urban Institute's survey of 1700 hospitals, which focused on the extent of medical care for the poor and the financial status of hospitals serving the poor. A summary of the information we have been developing and analyzing is likely to be helpful in understanding the situation of public hospitals today.

B. National Public Hospital Data

1. PUBLIC HOSPITALS CONTINUE TO TAKE ALL PATIENTS -- REGARDLESS OF ABILITY TO PAY

Where public hospitals exist, they are "de facto" national health insurance today. According to a 1983 NAPH survey, uncompensated care represented an average of 29% of 1982 inpatient days for NAPH member hospitals (or an average of 46,010 uncompensated inpatient days per hospital). 46% of all outpatient/emergency room visits to NAPH members, on average, were also uncompensated (106,000 uncompensated visits per hospital).

It should be noted that NAPH member hospitals maintained this "open door" while serving as an essential source of care for many insured patients as well, with each hospital averaging over 158,000 inpatient days and over 229,000 outpatient/emergency room visits by Medicare, Medicaid and privately insured patients.

How does this effort compare with other sectors of the hospital industry? The new AHA/Urban Institute Survey data enables us to compare the relative levels of care to the poor rendered by various categories of hospitals. In Table I, data is presented for hospitals, by ownership and geographical location, indicating relative proportion of charity care, bad debt and Medicaid for 1700 of the Nation's hospitals. The Urban Institute believes this data is sufficiently comprehensive to permit extrapolation of these trends to the Nation's 5700 acute care hospitals.

This table shows that hospitals in the 100 largest metropolitan areas accounted for most of the charity care (63%) and care to Medicaid clients (54%) and almost half of the bad debt (48%) incurred in the Nation. However, although public hospitals in those 100 cities represent only 5% of all hospital beds, their level of charity care -- 40.3% -- far exceeded the next highest group -- non-profit hospitals in these cities (22.5%, with over 26% of the hospital beds), whose primary low income patients were Medicaid recipients. Bad debt in public hospitals was, by bed size, proportionately four times greater than in non-profit facilities. In addition, the metropolitan area public hospitals averaged over $10 Million each in Medicaid care, compared to an average of $5.3 Million for non-profit facilities. Proprietary facilities in large cities provided

Table 1

Hospital Care to the Poor
by Ownership and Location

		Total Hospitals	Beds (percent of total)	Total Poor Care		Charity Care		Bad Debt		Medicaid	
				Amount (Mill.)	Percent	Amount (Mill.)	Percent	Amount (Mill.)	Percent	Amount (Mill.)	Percent
	Universe	5,719**	971,738 (100%)	14,389.1	100.0	1,849.8	100.0	3,494.3	100.0	9,045.1	100.0
A)	100 largest Cities	973	34.6	7,744.8	53.8	1,163.2	62.9	1,689.1	48.3	4,892.5	54.0
	Public	100	5.0	2,499.1	17.4	745.1	40.3	672.9	19.3	1,081.1	12.0
	Non-Profit	681	26.6	4,903.3	34.1	416.4	22.5	901.9	25.8	3,585.0	39.6
	Proprietary	192	3.0	342.4	2.3	1.7	0.1	114.3	3.3	226.4	2.5
B)	Other SMSA*	1,831	39.6	4,793.5	33.3	531.2	38.7	1,214.6	34.6	3,047.8	33.7
	Public	366	6.8	1,187.6	8.2	216.7	11.7	332.6	9.5	638.3	7.0
	Non-Profit	1,159	28.6	3,098.5	21.5	310.7	16.8	710.1	20.3	3,077.1	23.0
	Proprietary	306	4.2	507.4	3.5	3.8	0.2	171.9	4.9	331.8	3.7
C)	Non-SMSA	2,915	25.9	1,850.8	12.9	155.4	8.4	590.6	16.9	1,104.7	12.2
	Public	1,317	9.5	676.6	4.7	63.0	3.4	261.1	7.5	352.6	3.9
	Non-Profit	1,366	14.6	1,064.9	7.4	88.7	4.8	307.1	8.8	669.1	7.4
	Proprietary	232	1.7	109.2	0.8	3.7	0.2	22.4	0.6	83.1	0.9

* Standard Metropolitan Statistical Area
** Extrapolated from 1700 hospital sample

SOURCE: NAPH ANALYSIS OF AHA/URBAN INSTITUTE DATA an insignificant amount of charity care (0.1%) and experienced very little bad debt and Medicaid care (3.3% and 2.5% respectively).

In non-SMSA areas, although the amounts per bed were smaller, public hospitals provided 42% more charity and bad debt per bed than did non-profit hospitals and 135% more than did proprietary hospitals. Large urban public hospitals provided 358% more free care per bed than the average large city non-profit hospital, and provided 1,006% more free care per bed than the average large city proprietary hospital in 1982.

2. PUBLIC HOSPITALS HAVE NOT BEEN PART OF THE HOSPITAL INFLATION PROBLEM.

NAPH data shows an average annual inflation rate for public hospital budgets of just 9.8% per year between 1976 and 1980, as opposed to 14.7% for the hospital industry as a whole. And in just one state, California, all hospital costs in 1981 increased 17.9%, while public hospital costs increased by just 10.3%, indicating that this historical gap is continuing and may be widening. More recent data thus indicate that this trend is continuing on a national basis as well. We expect to have this data available for the Committee soon.

3. DESPITE THE PERSISTENT WASHINGTON, D.C. MYTH THAT CITIES AND COUNTIES ARE NOT PAYING THEIR WAY, A SUBSTANTIAL PORTION OF THE PUBLIC HOSPITAL BUDGET COMES FROM LOCAL TAX REVENUES.

NAPH data show that 31% of our members' budgets come from local appropriations, as opposed to 22% from Medicaid and 16% from Medicare. These local sources of revenue serve as the primary source of support for the average $29 million in bad debt and charity care rendered at 24 public hospitals in 1983, with $709 million from state and local non-Medicaid appropriations. And while public hospitals serve a large proportion of Medicaid and Medicare patients, there are relatively far fewer privately insured patients to whom costs can be shifted -- just 12%, on average, among NAPH members around the country.

The Urban Institute study has also revealed, from 1982 data, that almost 50% of large city public hospitals in the 100 largest cities showed a total margin deficit, compared to only 20% of the not-for-profits. Of those hospitals with a total margin deficit, the deficit for large city hospitals averaged almost six times higher than large city not-for-profits. Charity care and bad debt as a percent of charges is also about six times higher in deficit public hospitals than deficit not-for-profits.

Among hospitals in the nation's 100 largest cities defined as providing a "high volume" of care to the poor (greater than 13% combined Medicaid, bad debt and charity care), 32 public hospitals and 72 private hospitals reported operating deficits, averaging 14.75% for the public hospitals and 3.42% for the private institutions. Public hospitals in this category averaged lower Medicare days, but significantly higher Medicaid days and bad debt/charity care than "high volume" private hospitals, as follows:

Table 2 - Operating Deficit of Hospitals Serving the Poor

	"High Volume" Public Hospitals	"High Volume" Private Hospitals
	(n = 32)	(n = 72)
Beds (avg.)	360	326
% Medicare Days	30.89	42.58
% Medicaid Days	25.39	19.92
Charity care/Bad debt as % of charges	20.29	5.38
Total % Margin	-14.75	-3.42

4. THE NON-MEDICAID UNINSURED CASELOAD OF PUBLIC HOSPITALS HAS SUBSTANTIALLY INCREASED IN RECENT YEARS.

The August 1983 NAPH survey of unemployed and uninsured patients in public hospitals demonstrated that these facilities are now the source of health care for thousands of individuals who had relied on other health services before unemployment. 44% of the unemployed patients surveyed responded that they had not used the public hospitals as a regular source of care before becoming unemployed. Eight hospitals reporting inpatient and outpatient data had a total of 5506 unemployed and uninsured visits or admissions for a seven day period -- an average of 688 per hospital. If this number is projected for the year, these eight institutions alone will experience over 280,000 visits and inpatient days by uninsured and unemployed patients.

The newly unemployed comprise just one part of the increased indigent caseload of public hospitals in metropolitan areas. The problem is substantially exacerbated by reductions in Medicaid eligibility, and inadequate funding for special populations such as illegal aliens and refugees. Moreover, we believe we can also anticipate a significant increase in more severely ill Medicare patients, as private hospitals move to adjust their caseload to maximize reimbursement under the new DRG system.

New NAPH data for 1982 shows that just 17 public hospitals attributed 917,120 inpatient days to bad debt or charity care, or nearly 54,000 per hospital. Expenditures for unreimbursed inpatient care for just 20 of our members totalled $379 million in 1982, or nearly $19 million per hospital.

5. PUBLIC HOSPITALS ARE IMPORTANT PROVIDERS OF PRIMARY AND AMBULATORY CARE TO POOR PERSONS WHO OFTEN HAVE LITTLE OR NO ACCESS TO PRIVATE PHYSICIANS.

NAPH members average almost 106,000 bad debt and charity care outpatient and emergency room visits, representing about 50% of all visits at these facilities. These uncompensated care visits are a primary reason that public hospitals average 1.5-3 times the number of visits to all hospitals in the nation's 100 largest cities. In some states, the proportion is far higher. Atlanta's Grady Memorial Hospital, for example, in 1981 provided 28% of all the outpatient visits to hospitals in the entire state of Georgia. The costs for this care are high -- almost $11 million per NAPH institution.

Public hospitals also experience a far higher average level of admissions through the emergency room (over 41% for public hospitals in metropolitan areas, as compared with 25-33% for large city hospitals in general).

In addition to the great burden of outpatient/ emergency room charity care currently borne by public facilities in our nation's metropolitan areas, the Urban Institute study finds that high volume providers of care to the poor outside the 100 largest cities are reducing emergency room and outpatient hours or staff at a rate approaching twice that of low volume providers, suggesting that metropolitan public hospitals may have to care for these patients as well.

6. PUBLIC HOSPITALS IN METROPOLITAN AREAS ALSO PROVIDE SPECIALIZED TERTIARY CARE, PUBLIC HEALTH AND OTHER UNIQUE SERVICES.

These services are often too costly or too "unreimbursable" for most private hospitals to maintain. They include burn units -- trauma centers -- emergency alcoholism, drug abuse, and child abuse centers -- neonatal intensive care -- poison control units -- to name just a few. New Urban Institute data shows that public hospitals with operating deficits in the nation's largest cities were nearly four times more likely to have a burn unit, and about twice as likely to have neonatal, pediatric and psychiatric intensive care units than similarly located private hospitals.

7. PUBLIC HOSPITALS HAVE MANAGED THEIR RESOURCES EFFICIENTLY.

A recent study by Alan Sager, of Brandeis University, indicates that public hospitals have experienced the largest decrease in length of stay, and the only increase in occupancy rate, among all classes of hospitals in the nation's 52 largest cities. Moreover, public hospitals have decreased their total number of beds between 1970 and 1980 -- by over 22% -- in those cities. In addition, most public hospitals are already managed and budgeted prospectively each year, with full, independent review by State and local governmental entities.

8. IN SUMMARY...

Caring for the poor in our nation exacts a high price from our public hospitals -- higher costs, lower compensation and a stressed financial condition. And all of these factors are likely to have a severe impact on the ability of public hospitals to attract sufficient capital to enable them to fill this vital role.

Urban Institute data can also be cited to summarize this perilous situation(see Table 3). They have compared hospitals in the nation's 100 largest metropolitan areas by their costs, revenue and financial status (as measured by their operating and total margins). All hospitals in metropolitan areas generally averaged nearly $10 or $30 in surplus revenues per inpatient day, depending on whether they were characterized as "high volume" or "low volume" providers of care to the poor. Public hospitals as a separate group experienced a loss of almost $18 per inpatient day. In addition, their rate of revenue per inpatient day was $12-20 lower than the overall average for high volume and low volume hospitals (which includes all of the public hospitals in the sample). This situation is further exacerbated by the fact that the level of inpatient Medicaid payments per recipient for public hospitals - $1521 - is $230 less than average revenues per patient for all high volume providers (again, including public hospitals).

Finally, public hospital costs per inpatient day were also $17-$59 higher than high and low volume hospitals in general.

Public hospital losses per outpatient visit were well over twice the rate of losses experienced by high volume providers in general, while low volume providers actually experienced a revenue surplus from outpatient visits.

Charity care and bad debt as a percent of charges averaged 21% for large city public hospitals, almost twice the rate of the average for high volume providers in general. Finally, public hospitals are the only group to show a negative operating margin and a negative total margin -- characteristics indicative of financially stressed facilities.

Table 3

Selected Financial Characteristics of High and Low Volume Providers of Care to the Poor in the Nation's 100 Largest Cities and Public Hospitals in the 100 Largest Cities -- Urban Institute Sample

	Low Volume*	High Volume*	Public Hospitals
Cost per Inpatient Day	$235.14	$277.05	293.93
Revenue per Inpatient Day	264.02	286.93	274.95
Cost per Outpatient Visit	62.93	63.00	69.18
Revenue per Outpatient Visit	70.17	50.95	40.20
Charity Care and Bad Debt as a Percent of Charges	2.87	10.90	21
Surplus per Inpatient Day	28.89	9.88	-17.68
Surplus per Outpatient Visit	7.24	-12.05	-28.40
Operating Margin	3.4	-2.6	-.15
Total Margin	4.67	1.08	-1

* "High volume" providers are all hospitals with at least 13.54 percent of gross charges devoted to Medicaid, bad debt and charity care, while "low volume" providers are those which devoted 7.54% of their charges to those categories.

SOURCE: NAPH ANALYSIS OF AHA/URBAN INSTITUTE DATA

III. THE SITUATION OF PUBLIC HOSPITALS IN TEXAS

Public hospitals are particularly important providers of indigent medical care in Texas, which ranks 48th among the states in terms of Medicaid coverage. The Texas Medicaid Program covers only approximately 25% of those people below federal poverty guidelines and no one in the "medically needy" program category. Compared to their national counterparts, Texas public hospitals see fewer Medicaid and far fewer Medicare patients, and out of necessity direct their primary attention to indigent persons who have no form of coverage.

The level of local financing of hospital service for low income patients in Texas far exceeds the effort of the State Medicaid program. A new study by the Texas Association of Public Hospitals indicates that just five public teaching hospitals alone accounted for $330 million in locally-funded care for uninsured patients in 1982, or one-third more charity care than the total statewide Medicaid reimbursement for inpatient and outpatient hospital services.

But while Texas public hospitals do need, and receive, greater amounts of county ad valorem tax support than do public hospitals in other states, the amount of city-county tax support for Texas public hospitals has not kept pace with the rate of inflation. Public hospitals have had to absorb the difference within their operating budgets. They also have not received local support to offset the cuts occurring at the federal level. Just 1% of Texas hospitals provided almost one-third of the Texas Hospital Association's estimate of $1.6 Billion in uncompensated care provided by all hospitals in Texas. The cost of delivering uncompensated care for the large urban public hospitals was $62 Million more in 1982 than the ad valorem taxes received. This gap had to be absorbed by either shifting costs to privately insured patients, or by such mechanisms as underfunding of depreciation, or to other sources of revenue such as parking and cafeteria receipts or interest income.

Non-profit hospitals enjoy an exemption from taxation, yet most such hospitals contribute little in Texas to helping solve the uncompensated care problem. Nor do the taxes paid by for-profit hospitals in Texas represent more than a small percentage of the amount of indigent care provided by public hospitals. In Dallas County, 16 proprietary hospitals paid approximately $270,000 in taxes for 1983, and one hospital alone paid one-half of this total amount. For the same year, Parkland Memorial Hospital provided approximately $77 Million in charity care to indigent patients and received approximately $65 Million in tax support for its operations. The property taxes paid by proprietary hospitals amounted to only 2% of the $12 Million of underfunding. The underfunded portion alone of the cost of charity care at Parkland represented at least twice the amount of uncompensated care provided by any of the large urban non-profit teaching hospitals in Dallas. Texas county hospital districts are legally responsible for the care of indigent patients who are residents of their county. But there are also many less than indigent patients who are nevertheless uninsured or underinsured in Texas who require our services -- who cannot receive treatment at most private hospitals. Moreover, there are also numerous counties in Texas without hospitals, whose residents inevitably turn to us for their care.

The transfer of "self-pay, non-insured or unemployed" i.e., "medically indigent" patients to the public hospitals from non-profit and for-profit hospitals within the country is even more of a drain than out-of-county transfers. In fact, in 1983 the Dallas County Hospital District delivered $10.5 Million in out-of-county uncompensated care and over $12 Million in in-county care to "self-pay non-insured" recipients transferred from other institutions. During the recent recession and the initiation of the perspective payment system, transfers have become a problem of national importance. During this period, transfers to Parkland quadrupled. Clearly, public hospitals met their obligation to indigent care and they continue to exceed their mandate as "safety net providers" by accepting patients who represent a transfer of bad debt from private institutions. At a recent meeting of public hospitals, one chief executive officer commented that he was certain the world was not round after all, nor was it flat, but "funnel-shaped" -- with his hospital located at the bottom of the funnel.

The Dallas County Hospital District is also typical of the major public hospitals in Texas, and in other states, in the range of services we make available to all of our patients -- whether or not they can pay. Because we are a major teaching hospital, we are able to offer many specialized tertiary services, including burn care, neonatal intensive care, shock/trauma services, inpatient and outpatient dialysis, and transplants. We also serve as one of the busiest outpatient clinics in the nation, with over 200,000 visits per year (the majority of them uncompensated). And we provide many valuable social services as well. Table 4 indicates the service mix of a sample of major public teaching hospitals in Texas.

As a result of our service mix and our "open door" mission, Texas public hospitals now find themselves caught between reimbursement reductions from the federal government and increased service demands. Our hospitals are typically associated with a medical school and to a major degree depend upon the medical school's faculty for the provision of direct patient care or supervision of house staff

Table 4

Special Services Provided by Selected Texas Public Teaching Hospitals

Services Provided	Dallas CHD	Bexar CHD	UTMB	Harris CHD	El Paso CHD	Lubbock CH
Trauma center	X	X	X	X		X
Burn center	X		X	X		X
Skin transplant	X		X			X
Acute psychiatric services	X	X	X	X		
EMS program	X	X	X			X
Rape crisis	X		X			X
Renal transplant	X	X	X			
Adolescent high-risk program	X	X	X			X
Neonatal ICU	X	X	X	X	X	X
Interpreter services:						
Language	X	X	X	X		
Hearing impaired	X	X	X	X		
Transportation	X	X	X	X	X	
Patient education	X	X	X	X	X	
Social services	X	X	X	X	X	

CHD = County Hospital District; UTMB = University of Texas Medical Branch physicians. Since the state has not increased clinical faculty positions to keep up with increasing service demands, medical schools are now turning to the public teaching hospitals for financial underwriting of clinical activity felt to be over and beyond the medical school's mission of education and research.

The majority of Texas public teaching hospitals find themselves with aging plants which have not had adequate funding for depreciation. They also may have sacrificed routine maintenance and equipment replacement in order to purchase desirable and innovative technologies for their faculties. The need to focus resources on acute care services for indigent patients has precluded sensible and innovative use of monies and support personnel to improve the delivery of services. Hence long lines and long waits, for example, typify public hospital clinics and emergency rooms. This has resulted in two classes of care in Texas and the situation is likely to become worse during the era of prospective reimbursement and DRG's.

The assumption that all well managed hospitals will survive prospective payment and DRG's is a sophomoric assessment. Hospitals that stay true to their mission of providing indigent health care and support for medical and nursing education, and tertiary care services, may have difficulty surviving because they are carrying a disproportionate share of the responsibility for these costs. If we are to be thoughtful in our approach to a solution, it will have to address "leveling of the playing field" so that hospitals of different governances can compete fairly.

IV. Impact on Public Hospitals of Recent Regulatory and Competitive Reforms

In this final section of my testimony, I would like briefly to summarize the impact on the Nation's public hospitals of several recent health system reforms which have been implemented or proposed by Congress, by the States, and in our local health system. The purpose of this summary is to indicate the extent to which we believe the financial situation of our present health "safety net" is likely to deteriorate in the future as a result of present trends, in order to lay the groundwork for your consideration in subsequent hearings of possible future reforms.

A. Medicare Prospective Payment System

At the time Congress enacted the new Medicare prospective payment system, NAPH expressed serious concern that the new system would not adequately account for the special characteristics of public hospitals and their patients. In particular, we were concerned that Medicare patients in public hospitals were likely to be sicker, with more complications, than their counterparts in private hospitals, and that the special costs associated with treating low-income patients in general would not be accounted for in a single-price prospective system. As a result, the Congress included in that legislation an amendment which required the Secretary of HHS to determine the extent to which it would be necessary to provide exceptions, adjustments or some other form of relief for those hospitals (public and private) which serve a "significantly disproportionate share of low income and Medicare patients".

This amendment was virtually identical to a similar requirement adopted by Congress in TEFRA; Like the TEFRA provision, this new amendment has been virtually ignored by the Administration. Not only has the Administration failed to authorize specific adjustments or exceptions for such hospitals, the Health Care Financing Administration has failed even to develop criteria for defining "disproportionate share", or for identifying hospitals meeting such criteria, so that their costs and needs could be be individually and accurately assessed. Subsequently, the Congress acted earlier this year, in the Deficit Reduction Act of 1984, to order the Secretary to report back by December 31st on the identity and location of such hospitals.

In addition, the federal courts have now also expressed serious concern in this area. In particular, the Federal District Court for the Northern District of California, in

Redbud Hospital District v. Heckler, has ordered the Secretary (among other things) to implement "regulations or policies" with regard to the special needs of "disproportionate share" hospitals. It is not yet clear whether the Secretary intends to appeal this decision.

Meanwhile, however, we have begun to accumulate a significant amount of data indicating that this Congressional and judicial concern has been well placed, and that public and other "disproportionate share" hospitals are indeed likely to be disadvantaged under the new PPS system.

Our preliminary analysis of this new data, some of which has been released as recently as three days ago, indicates the clear need for some form of exception or adjustment for such hospitals.

We have, for example, begun to develop data indicating that the case mix of hospitals serving disproportionate numbers of low income patients is substantially different from the national average, with more outliers, and a greater proportion of cases in DRGs with considerably greater internal uncertainty and variation.

When we first testified before this Committee on the PPS System, we submitted preliminary data gathered by researchers, such as Jeffrey Merrill and Michael Schwartz, which included findings such as the following:

- Public hospital septicimia patients are 2 1/2 times more likely to have tuberculosis than those in private hospitals.

- Substantially more public hospital diabetes patients have complications than in private hospitals.

- 3.5% to 7.1% of all public hospital discharges are "outliers", with longer than average length of stay, as compared with 1.7% to 3.9% in nonpublic hospitals.

- 90% of "outlier" discharges with cerebro -circulatory admissions come into public hospitals through the Emergency Room.

- Public hospitals treat significantly more patients with infectious diseases, mental disorders, and ill-defined conditions and injuries (e.g. accidents, violence) than private hospitals.

Subsequent analysis has underscored those findings. For example, we asked Systemetrics, Inc., to study Bellevue Hospital patients, using their "disease staging" methodology. Their preliminary analysis was that over 30% of Bellevue's patients were in more complicated stages, requiring more resources, as opposed to just 24% of patients with similar diagnoses in ten private urban teaching hospitals.

D.C. General Hospital is an NAPH member that has been under the new PPS system since its inception, due to the questionable honor of an October 1 fiscal year. Their preliminary analysis, set out in Table 5, indicates a substantially greater prevelance of Medicare DRGs more likely to be associated with low income patients -- and with multiple complications. The second most prevalent D.C. General Medicare diagnosis, for example, has been DRG 296 (Nutritional and Miscellaneous Metabolic Disorder), and the fifth most prevalent is DRG 294 (Diabetes). Together, these two diagnosis have accounted for 7.1% of D.C. General's Medicare admissions. In addition, 4.4 percent of D.C. General's admissions were in the "unrelated" and "ungroupable" DRGs 468 and 470. Noticeably absent from D.C. General's Medicare admissions were such national "top 10" DRGs as #243 ("medical back problems"). We are now seeking to replicate this analysis for NAPH members nationally.

Table 5

District of Columbia General Hospital

Comparison of 10 Most frequent Medicare DRGs: Hospital

Specific vs. National

(* = connotes DRG which does not appear on both lists)

		National		D.C. General Hospital		
Rank	DRG No.	Description	% of Nat'l Discharges	DRG.No	Description	% of DCGH Discharges
1.	127	Heart failure + shock	4.9%	127	Heart failure + shock	5.8%
2.	039	Lens Procedure	4.0%	296*	Nutritional & Misc. Metabolic Disorder	4.4%
3.	182*	Esophagus, Gastro-Enteritus + Misc. Digestive Disorders	3.7%	014	Specific Cerebrovascular Disorders	3.2%
4.	089	Simple Pneumonia and Pleurisy	3.3%	468*	Unrelated or Procedure	2.7%
5.	014	Specific Cerebrovascular Disorders	3.1%	294*	Diabetes, Age 36	2.7%
6.	140*	Angina Pectoris	2.9%	039	Lens Procedures	2.2%
7.	088*	Chronic Obstructive Pulmonary Disease	2.1%	138	Cardiac Arrhythmia + Disorders	1.9%
8.	138	Cardiac Arrhythmia	2.0%	470*	Ungroupable	1.7%
9.	243*	Medical Back Problems	2.0%	089	Simple Pneumonia and Pleurisy	1.7%
10.	096*	Bronchitis and Asthma	1.9%	087*	Plumonary Edema + Respiratory Failure	1.6%
			29.9%			27.9%

Michael Perot, Director
Cost & Reimbursement Branch
August 10, 1984

We have recently surveyed NAPH members nationally regarding the general impact on revenues and costs of both TEFRA and the new PPS system. With 27 respondents to date, it seems clear that the concept of "budget neutrality" is simply not working for large public hospitals. Following the imposition of the TEFRA payment methodology, it appears that average total Medicare revenues for respondents increased by $1.93 Million, while average costs increased by $1.01 Million. In the first year of PPS, however, average Medicare revenues have decreased by $2.46 Million, while average Medicare costs have increased by $1.1 Million. Moreover, it appears that the patient care revenue figures for both periods may in fact be overstated, due to the inclusion by some hospitals of their teaching cost adjustments in these figures. Even from this data, however, it appears that Medicare is no longer paying public hospitals at least some portion of the extra costs incurred to meet the special needs of low income patients.

In addition to our own surveys, and as summarized in Part II above, new Urban Institute data clearly show that hospitals with a higher incidence of low income patients have significantly lower profit margins, operate more often with a deficit, and are in significantly worse financial shape generally than hospitals that do not.

HHS has contended in the past that it has seen "no evidence" that higher Medicare costs could be attributable to a greater proportion of low income patients in public and other "disproportionate share" hospitals. However, after considerable consultation with HCFA officials, we have reason to believe that analysis of HHS' own data will disprove that statement. We are convinced that historically higher Medicare costs in such hospitals will be found to be due in significant measure to serving low income patients -- and that this factor can be measured apart from the impact of bed size, urban location, teaching program, and other factors previously thought to be surrogates for this important element.

Our expectation with regard to HCFA's internal analysis has been underscored significantly by the findings in a new study released only this week by the District of Columbia Hospital Association. DCHA surveyed 257 hospitals in five metropolitan areas and determined that the overall costs for patient care in inner city hospitals with higher low income case load are significantly higher than in suburban hospitals. Furthermore, DCHA found a direct correlation between higher costs and care for low income patients even after correcting for the impact of a teaching program and such other factors as bed size, case mix index, and wage index. We would be happy to provide copies of the DCHA study for finance Committee members and staff.

For these reasons, we continue to believe that it is essential for Congress to insist on the implementation of the "disproportionate share" provision, in order to protect and preserve essential services important to all participants in the health care system, and which we believe are essential to the fiscal stability of that system. Congress should start with an insistance that HCFA meet its December 31 deadline for developing criteria for defining what constitutes a "disproportionate share" of low income patients and identifying hospitals meeting such criteria. Again, HHS's own data can enable the Department to measure the relative proportion of hospital revenues, costs, or admissions attributable to Medicaid patients, "self-pay" (i.e., uninsured) patients, bad debt, Hill-Burton care, other charity care, and the proportion of patients whose care may be partially paid for by publicly funded grant programs, such as maternal and child health.

B. Impact of Medicaid Changes

In addition, the varied experiences of several states in implementing similar requirements in the Medicaid program may also be enlightening to HHS and this Committee.

In 1981, the Congress gave states considerably greater flexibility to set Medicaid rates for hospital reimbursement. In so doing, however, Congress also recognized the need to protect "disproportionate share" hospitals, enacting an amendment quite similar to the TEFRA and PPS amendments discussed above. Specifically, a state's Medicaid plan was required by the 1981 amendments to provide for payments "through the use of rates which ... take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs...".

With regard to this provision, as with regard to the Medicare provisions, the Department of Health and Human Services has provided virtually no guidance to states beyond the simple requirement that state plans reflect this statutory mandate. A new report prepared for the National Health Law Program now documents the extent to which individual states have (or have not) actually implemented this provision. State reactions can be divided into several general categories.

First, and perhaps most disappointing, HCFA has maintained that those 25 states which still use Medicare cost principles are deemed to be "automatically" in compliance with the provision, as are five additional states which have operated their Medicaid programs under "all payer" systems.

Twenty states, however, have implemented new reimbursement methodologies subsequent to the enactment of the 1981 amendment. Of the twenty, four have not defined "disproportionate" (Florida, Nebraska, North Carolina and Oregon). Rather than paraphrase, we think it is worthwhile to provide the Committee with lengthy excerpts from the NHLP report regarding the experiences in those states which have chosen to define this term:

> "[E]leven of those states wrote their definitions in terms of Medicaid patients only. They did not consider uninsured patients when determining which hospitals served a "disporportionate number" of low income patients. Not only does the statute include the words "low income patients," the Committee Report discussed the intention that this provision apply to Medicaid and uninsured patients. It is estimated that almost thirty-three million Americans have no health insurance. 41/ It therefore seems unreasonable for HCFA to approve state plans which blatantly ignore this large portion of the statute's targeted population.
>
> "The states which base their definitions solely on Medicaid revenues range from requiring as low as 8% Medicaid revenues (Virginia) to as high as 51% (Iowa). Wisconsin used a "top 3%" approach where hospitals are indexed according to the combination of Medicaid revenues and medical education costs. The four states which consider Medicaid and other low income patients are California (in its peer grouping program only), 42/ Minnesota, Missouri, and Nevada. California includes revenues from other public programs but excludes Medicare revenues. Minnesota considers General Assistance medical care. Missouri includes all government sponsored patients in its definition. Nevada conscientiously considers all patients without resources, but since no hospitals in the state qualify as serving a disproportionate number of low income patients - its definition was not applied conscientiously.

States have also differed widely on their definition of how they are required to "take into account" the needs of such hospitals, although there may be some guidance here for HCFA in its efforts to respond to the congressional and court ordered mandates. Again, to quote from the NHLP report:

The number of hospitals which qualify under the states' definitions range from zero (Iowa and Nevada) to thirty-six (Pennsylvania). HCFA approved Iowa's plan when its qualifying definition (greater than 51% Medicaid patients) eliminates every hospital in the state. This definition is unrelated to the average low income patient load in the state's hospitals - it does not represent a disproportionate number of low income patients for the state.

The definition of "disproportionate number" is essential to the effective implementation of this law. In order for a state to be in compliance with the law, it must consider (1) Medicaid and (2) uninsured patients and (3) the percentage must be related to the average low income patient population of the state's hospitals. For example, Alabama defines disproportionate number as one standard deviation above the average Medicaid utilation rate. This is a good first step in establishing a clear definition. If Alabama considered both the Medicaid population and the uninsured poor, this revised definition would be a model definition of disproportionate number because it would meet all three criteria.

The standard deviation is a useful measurement in this context because (1) it is a precise statistical device; (2) it is a well known measure of variability; (3) it would allow a cutoff percentage for qualification to vary according to hospital usage patterns of the different states. One standard deviation above the mean would account for approximately 84% of the hospitals in each state. If a state used this device to determine which hospital served disproportionately more low income patients than the average hospital, approximately the top 16% of hospitals which serve the most low income patients in the state would qualify. 42a/

There are no standards in the regulations as to how a state must "take into account" qualified hospitals in determining their rates. Unless the method for taking the "disproportionate number" hospital "into account" is clearly defined, how many hospitals qualify is meaningless. The only related regulation which states must meet is the provision of an appeals process. 43/ According to this regulation, hospitals must be given the opportunity to appeal their reimbursement rates. In seven state plans, this is the only consideration given to hospitals serving a "disproportionate number" of low income patients (Georgia, Iowa, Nebraska, Missouri, Nevada, North Carolina, Oregon). Administrative appeal rights are not sufficient procedures for states to be considered in compliance with this specific "disproportionate number" provision. Appeal rights do not insure that the special costs incurred by hospitals that serve a disproportionate number of low income people will be recongnized in their reimbursement rates.

The "sliding scale" method of taking hospitals into account is the best way we have seen to date to satisfy the intention of the "disproportionate number" provision. Seven states (Alabama, California, Michigan, Minnesota, Mississippi, Pennsylvania, Virginia) take the qualifying hospitals into account using a sliding scale where the limit on the hospitals' reimbursement rate increases proportionately to the percentage of Medicaid patients (ideally this should include all low income patients) served above the qualifying minimum. For example, California's "peer grouping" program entitles a hospital to receive additional reimbursement according to a published chart.

> California State Reimbursement Plan, September 27, 1983, Attachment 4.19-A, p. 7.
>
> Disproportionate share hospitals with rates per discharge above their peer group's 60th percentile will be additionally reimbursed at a percent of the difference between the 60th percentile and its rate per discharge, according to the following schedule:

If the disproportionate share is:	The additional reimbursement % applied to the amount above the 60th percentile is:
95% - 100%	50%
88% - 94%	45%
81% - 87%	40%
74% - 80%	35%
67% - 73%	30%
60% - 66%	25%
53% - 59%	20%
46% - 52%	15%
39% - 45%	10%
32% - 38%	5%

The hospitals with similar characteristics are grouped together, and the 60th percentile of all their costs (i.e., a little above the average cost) is considered the target cost of the "efficient hospital." If the "disproportionate number" share is 40%, then 10% is applied to the amount in actual cost above the 60th percentile. If the 60th percentile equaled $100 and a hospital with 40% low income patients experienced an average discharge cost of $125, Medicaid would pay 10% of the $25 (difference) of $102.50 per discharge. If the hospital serves 50% low income patients, then Medicaid would pay 15% of the actual cost above the 60th percentile or $100 + 15% ($25) = $103.75 per discharge.

In theory, the sliding scale approach provides increased compensation in proportion to the percentage of low income clients served. All disproportionate number hospitals are reimbursed at a higher rate than other hospitals serving Medicaid patients. The sliding scale approach also provides hospitals with something concrete to appeal. If a hospital serves x% low income patients, its administrators can calculate the reimbursement rate it is entitled to."

We will be happy to provide the Committee with copies of the full NHLP report, and we would ask that it be printed in the hearing record.

C. The Impact of Other Health System Reforms

Other governmental health system reforms with the potential to assist public hospitals have been largely notable by the failure of Congress to enact them. Apart from a modest but welcome expansion of maternal and child health coverage in the 1984 amendments, Congress has thus far considered, but stopped short of enacting, efforts to provide health coverage for the unemployed, direct grants to public hospitals, and additional financing for programs serving illegal aliens. In each case, we have worked hard to achieve committee approval, and in several cases approval by the full House, of these provisions, only to see them flounder for various reasons.

If the federal government has merely refused to assist public hospitals, more effective "reforms" in the private sector promise to substantially damage our ability to provide services. As trends increase toward the development of PPOs and other alternative private insurer discounting arrangements, we are hit by a double edged sword: on the one hand, we are usually too costly, for reasons often beyond our control, to participate on an equal footing in such ventures ourselves. Therefore, we risk losing such private patients as we have. On the other, as these arrangements increase pressure on private hospitals, we will be forced to receive those less economically viable patients they are no longer willing to treat.

To be sure, a number of NAPH members are going to try to compete in this system -- those whose physical plant, service mix, fiscal situation and patient load permit. Some of us will form or join (or even start) PPOs or HMOs, and even try to develop such new entities for our Medicaid and indigent patient populations. But you must recognize that this will be an uphill struggle for many public hospitals, and if you also believe that we are important elements of the present health care system, then you must be prepared to assist us in this area as well.

In conclusion, I would like to offer one last general observation about the rush to find "more business-like" solutions to the crisis in health care financing. We are involved in and witnessing a process whereby hospitals of all kinds are being converted from charitable, social institutions to economic business ventures guided by the principles of profit and loss. Buzzwords like "market-share," "competition," "efficiency," and "bottom line" now govern the non-profit as well as the for-profit hospital industry -- conceivably at the loss of goals such as access, quality and compassion. Hospitals did not necessarily create this new system -- although hospitals certainly contributed to its creation through a complacent inefficiency generated by years of cost-plus reimbursement. But that has certainly not prevented most hospitals from jumping on the "competitive" bandwagon with a vengeance -- particularly those who believe their very future depends on it. And those of our citizens rich enough or lucky enough to have health insurance will no doubt reap economic benefits from this overarching attention to cost.

The cost of maintaining quality and a state of preparedness in tertiary care for all persons, regardless of ability to pay, should be viewed as a legitimate cost for a vital community need much like the premiums for a health insurance policy you hope you never have to use. This cost could be supported either on a regional or statewide basis (the broadest tax base possible) and not on a per case basis. This reform could be accompanied by a variety of potential reforms, including Medicaid improvements, increased participation by Medicare, and various kinds of state pooling arrangements, including catastrophic insurance. All payer systems, in those states politically suited to them, are also worthwhile _if_ they provide for uncompensated care.

True reform in our sector, as well as for insured individuals, will mean moving beyond the idea that we require full reimbursement for charges, or even "fully allocated costs", for serving indigent and medically indigent patients. We need to learn from private industry, and recognize the opportunity of allocating our marginal capacity and productivity. Obviously, after fixed expenses are underwritten, new money can stabilize hospitals that otherwise might fail. The stabilization of rural hospitals and urban public hospitals can improve access to the poor and non-poor alike if funding is fair and equitable, even if not necessarily as much as providers would like. The same can be true for physicians who wish to participate in such a program of reimbursement based upon negotiated rates, _i.e._, the specified or "preferred" provider concept. Independent provider health maintenance organization alternatives can also be used to place proper incentives into the system for preventive health care and provider utilization reviews. But aggressive federal financial participation is essential in such a system, if it is to work.

We should be innovative and step back from the current system enough to allow a little introspection. We should not lose sight of the dream of an appropriate level of health care access for everyone. This can only be achieved if providers and the government jointly accept the responsibility to make that access available in an efficient, effective and dignified manner.

Health care needs to be run like a business, but it is not "just business." Society expects more from us and that is one of the reasons that competition on an unlevel playing field will never yield equity nor will it improve access for the poor. Hopefully, the public hospitals in Texas will never need to change their mission and curtail their contributions to tertiary care, innovation in community medicine, and teaching in order to retrench to a mandated level of participation. Public hospitals must lead this reform by efficiently managing their operations so that more health care can be bought with the dollars currently available. The days are over when public hospitals could afford to behave as though they were insulated from the realities of the marketplace and sound business principles. On the other hand, public hospitals in Texas and elsewhere need to be funded at a level that allows for depreciation, new technology and the development of programs for preventive health to ultimately decrease the need for future growth in acute care delivery systems. Our institutional health safety net in Texas is at a crossroads which mirrors the situation in other parts of the nation. The right decisions now could prevent a "separate but equal" approach to health care that will work no better in our health system than it did for education, while preserving and protecting those hospitals which serve as the foundation of that system.

Today, America is returning rapidly to a two class system of health care -- one composed of private providers competing for insured, generally healthy individuals and the other consisting primarily of the network of public (and a few private) hospitals serving the needs of the indigent and severely ill who have no access to mainstream medical care. All of this is being done in the name of cost reduction, competition and private entrepreneurial spirit.

In order for public hospitals to live in this new world, there must be an explicit recognition of these changes and recognition of the critical role of public hospitals. Measures must be taken to safeguard our survival and, therefore, access to health care for the nation's poor. In addition, we believe the sweeping changes in Medicare reimbursement -- from DRGs to the extraction of a much higher out-of-pocket cost from the beneficiary -- will increasingly require us to serve the elderly as well. My colleagues in the public hospital sector are absolutely convinced that this will occur -- particularly with those Medicare patients likely to be "outliers" in private hospitals, and those who will no longer be able to afford substantially increased premiums, copayments and deductibles. As the private sector makes its business decisions only we, the public hospitals, will, to the extent that we can survive, remain to care for America's most vulnerable populations.

STATEMENT OF ROBERT M. HEYSSEL, M.D., PRESIDENT, THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD, AND JOHN A.D. COOPER, M.D., PRESIDENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, DC

Senator **Durenberger**. Are you coming back next Monday, by the way?

Dr. **Heyssel**. No, sir; I can't be here, regrettably.

Thank you for asking the association to comment, Senator Durenberger. These hearings are terribly important and certainly important to society as a whole—those who are unable to pay for their medical care as well as the medical care system and hospital system and teaching system as we know it today.

I don't plan to go through my written testimony, which has been submitted.

Senator **Durenberger**. It will be made part of the record.

Dr. **Heyssel**. I do want to make a couple of comments, and I can't help but comment on one historic fact, your earlier question of "Why should I"—or why should we, any of us—"pay for the poor?"

In 1974, Mr. Hopkins who made possible the Johns Hopkins Hospital and University, gave a charge to the hospital and said, "You will take care of the poor in Baltimore." And he gave a charge to the trustees: "And you will build facilities to take care of those who can pay, so you can take care of more than the poor in Baltimore." He clearly had a notion—he may have been the first cost-shifter, I guess is my point. [Laughter.]

Because Mr. Hopkins had made a lot of money I think he understood the differences and the subsidies.

Senator **Durenberger**. Well, I will tell you, Will and Charley Mayo did the same thing, and they are coming from all over the country now.

Dr. **Heyssel**. Second, your comment that legislators find it easier to continue a hidden tax is also very true, and I was discussing with one of the Maryland legislators the question of the fact that when they put a limit on Medicaid they were simply shifting costs over onto another sector, and this kept them from having to raise taxes to support the Medicaid Program. He said, "You're absolutely right. It's much easier to do that than to raise taxes."

I would like to make another point, and it's been said here today, too, that it is a fact that the public teaching hospitals provide a disproportionate share of charity care. However, the averages can be very misleading. There are a lot of private voluntary hospitals out there in urban areas—and it's been noted that many of the public hospitals have closed across the country—who render an enormous amount of charity care, my own institution being one of them. And so we've got to recognize that generalities are fine but they don't get at the issue in all locales and in all hospitals.

I know that in your hearings that you are going to talk about graduate medical education, and just let me comment that from a teaching hospital's viewpoint there are a range of issues here that need resolution.

If, in the new competitive environment and so forth, we lose our base of support for one thing, we lose it for several, or we begin to make really hard choices about what we are going to do—whether we are going to stay in the education business the way we are, or whether we are going to meet our obligations to the community for care for the poor, whether we can afford some special services, regional services and so forth.

So the issue of uncompensated care is an enormously important one for the teaching hospitals, because, as I say, inevitably if we are squeezed on that we are probably going to have to give up one or another societal contributions which I think are important.

Finally, you asked that we comment on any financing mechanism incorporated in the State rate-setting mechanisms, and as you know, in Maryland we have an all-payors system—rates set for the hospital. And incorporated in that originally was a mechanism to recognize, one, differences between hospitals—teaching, nonteaching, and so forth; two, their level of bad debt and charity; and three, all payors participate.

We thought—wrongly—that we were probably somewhat immune from competitive forces. That clearly isn't the case, particularly as large employers now become increasingly self-insured. I think there view is that "we gave at the office" for the poor, for the graduate medical education, for research. I understand that position. If you ever read in Washington some of the hinterland papers like the Baltimore Sun, you have seen a lot about an organization called Select Care that Blue Cross is going to do.

"Select Care" is effectively a mechanism for selecting the low-cost hospitals, transferring routine patients, by patient direction and by insurance premium changes, to those low-cost hospitals out of the so-called high-cost hospitals. The high-cost hospitals end up being 10 hospitals—8 of them are in the inner city in Baltimore two of them are in Prince Georges County. They happen to be characterized by containing all of the teaching hospitals in the State that have a major share of the teaching; they happen to be characterized by the highest average uncompensated care, bad-debt, charity-care thing. They happen to be the hospitals that take care of the largest part of the minority populations in Baltimore, and in effect what we will do is to take patients out of those hospitals, put them in lower cost hospitals, eroding the base of those hospitals' ability to care out those other functions. They also happen to be the hospitals that have the regional burn centers, trauma centers, neonatal intensive care units, and all the special services that have in fact pretty much been mandated and/or placed in those institutions by both Federal and State planning actions.

So we have to find a way to deal with that. One of the things being considered in Maryland now is to begin to try to level the playing field on some of these issues by explicitly funding, through one form or another, a fund which would then be distributed in proportion to bad debts and charity care, in particular, hospitals and take it out of their rate base.

We are probably going to have to consider that for graduate medical education, including some limitations on how much we are willing to pay for. We are going to have to consider that specifically for research and research technology transfer within certain hospitals. Those things I think simply have to happen if we want to take advantage of both the competitive system that now is in place—and no one is going to stop that, it seems to me—and at the same time preserve some of the societal contributions that hospitals in the medical care system have to make for its overall good.

Thank you.

Senator DURENBERGER. Thank you very much, Dr. Heyssel.

Judith Ryan?

[Dr. Heyssel's written testimony follows:]

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Uncompensated Care and the Teaching Hospital

Presented to the
Subcommittee on Health, Finance Committee, U.S. Senate

by
Robert M. Heyssel, M.D., President, The Johns Hopkins Hospital
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September 28, 1984

aamc

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The Association of American Medical Colleges is pleased that the Subcommittee on Health of the Senate Finance Committee is continuing to study health care for the economically disadvantaged. As the hospitals of our nation confront and adapt to a more traditional commercial marketplace, we must give adequate attention and respond to both the health care needs of our poorer citizens and the financial needs of the hospitals and health professionals who care for them.

Because of the long and distinguished history of hospitals such as Bellevue Hospital Center in New York, Cook County Hospital in Chicago, and Los Angeles County Hospital, many people perceive the non-Federal members of the Association's Council of Teaching Hospitals (COTH) as "charity care teaching hospitals." Charity care and medical education are assumed by some to be necessarily interdependent objectives of major medical centers. There is some validity to this perception. First, in 1980, non-Federal COTH members, which comprise 6% of the nation's community hospitals and 18% of their admissions, incurred 35% of the bad debts and 47% of the charity care. Secondly, many municipally-sponsored "charity" hospitals historically have had difficulty recruiting an adequate number of physicians. To provide appropriate and necessary medical services to their patients, those hospitals have often affiliated with local medical schools to obtain the professional medical services which are provided by residents training under faculty supervision. These affiliation arrangements have benefitted both the patients receiving care and the physicians receiving supervised training. Thirdly, when states and municipalities have authorized appropriated funds to help finance hospitals with disproportionate charity care populations, the funding has sometimes been given an educational label to either increase its political acceptability or to channel it to particular hospitals. These three relationships between teaching hospitals and charity care have left many in our nation with the stereotypical view that the terms "teaching hospital" and "charity care hospital" are synonomous.

This perception is not completely accurate, and its perpetuation can hamper appropriate discussions of the options for addressing uncompensated care. It should be noted that the uncompensated care burden of COTH members is bimodal: some COTH members, both publicly owned and not-for-profit, provide vast amounts of uncompensated care but many provide an amount comparable to non-teaching, non-profit hospitals. Secondly, it must be recognized that medical students and residents can be trained without charity care patients. Therefore, if the issue of uncompensated care is to receive the attention it deserves at this hearing, we must separate the issues of uncompensated care and medical education wherever possible and address them separately. The balance of this statement will focus primarily on financial and organizational impacts of providing necessary care to patients who do not pay for it.

At the outset, several observations should be made to help ensure a common frame of reference. First, major amounts of uncompensated care are presently being provided by the nation's hospitals. The expenses necessary for this care -- staff, supplies, facilities, and equipment -- are already in the present hospital system. While the financing of those services is a "hodge-podge" of cost shifting, philanthrophy, lost earnings and appropriations, hospitals currently are able to provide massive amounts of uncompensated care. What is most at risk in the re-structured environments is that the self-focused cost containment efforts of individual third party payers and self-insured employers will silently squeeze the present level of funding for uncompensated care out of the system.

This is related to a second observation: the increases in the price consciousness of buyers of hospital services places hospitals with large uncompensated care burdens at a significant and growing disadvantage. In the absence of a comprehensive entitlement program for financing health services of the poor and medically indigent, hospitals have historically set their prices to subsidize uncompensated care with funds from their paying patients. In a marketplace of price sensitive consumers, hospitals which attempt this cost shifting to underwrite uncompensated care will be at a disadvantage. Their necessarily higher prices will make them less attractive to paying patients, and, as paying patients choose cheaper hospitals without the uncompensated care "surcharge," the financial problem of the hospital with a major uncompensated care burden will get worse and worse.

This leads directly to the third observation: the increasingly competitive marketplace for hospital services is forcing hospitals to balance the costs of uncompensated care for current patients with the hospital's fiduciary responsibility to remain viable in order to serve future generations of patients. It is a major ethical dilemma when a hospital finds that adequately serving its present community may preclude its ability to exist in the future.

Finally, the AAMC must note that teaching hospitals have historically filled special missions as a consequence of their location. Teaching hospitals are primarily in metropolitan areas; the largest are generally in inner city neighborhoods. In response to the hospital's location and the area's shortage of health personnel, teaching hospitals have often established large clinics and primary care services to meet neighborhood needs, even at a financial loss. The teaching hospital's area-wide programs for burn, trauma, high risk maternity, alcohol and drug abuse, and intensive psychiatric care may also attract patients unable to pay for their care. As a result, many public and private teaching hospitals are major providers of uncompensated care.

The bottom-line conclusion of these observations is clear: uncompensated care is a major problem in a competitive environment because uncompensated care is unevenly distributed across hospitals. This uneven distribution in a competitive market handicaps hospitals serving the indigent and medically indigent and benefits hospitals with primarily paying patients.

AAMC Actions

During the past year, the Administrative Board of the Council of Teaching Hospitals and the AAMC Executive Council have been engaged in a strategic planning effort for the Association's hospital activities. After a thorough review, it has been determined that one of the most important issues presently facing COTH is the future financing of uncompensated care. Association efforts are now giving added emphasis to this issue. The first step in developing efforts in the area of uncompensated care has been an attempt to review the research about uncompensated care patients. To date, the staff review has identified seven primary concentrations of uncompensated care:

- obstetrical and pediatric patients,

- chronically ill patients repeatedly admitted,

- patients awaiting placement in a less than acute care setting,
- patients admitted for catastrophic medical services such as burn or trauma care,
- uninsured patients including the unemployed and illegal aliens,
- patients who have abused drugs and alcohol, and
- insured patients unable to pay copayments and deductibles.

In individual teaching hospitals, the mix of these seven types of patients varies substantially. Nevertheless, the finding that uncompensated care patients can be categorized suggests that focused responses can be developed to assist these patients.

To maintain present levels of assistance for these types of patients, the AAMC has continually lobbied Congress to retain adequate funding for the Medicaid program. The AAMC opposed the three year reduction in Medicare funding enacted in 1981 and opposed the unsuccessful efforts to extend those reductions this year. The Association also actively supported this year's successful effort to expand Medicaid coverage for first time pregnant women, pregnant women in households where the primary wage earner is unemployed, and children under five.

The second step in developing efforts in the area of uncompensated care has been to review and follow the growing body of research seeking to identify the characteristics of hospitals with atypical burdens of uncompensated care.

Initial findings indicate that the most heavily burdened hospitals are publicly sponsored hospitals in metropolitan areas and not-for-profit hospitals in decaying inner city neighborhoods. Once again this suggests the possibility of developing categorical or focused solutions.

A number of alternative solutions are presently being tried and the Association is reviewing carefully their impact on COTH members. The all payer approved charge systems in New Jersey and Maryland have assisted COTH members with atypical uncompensated care burdens. The enthusiasm for this approach is not uniform throughout the Association membership. The recent experience in which Blue Cross of Maryland developed a preferred provider program giving patients financial incentives to use suburban hospitals with little uncompensated care rather than downtown hospitals with substantial uncompensated care costs included in approved rates may weaken the enthusiasm of those who support this approach.

Because of the recent Maryland experience, members and staff are giving increased attention to the "revenue pools" established in New York and Florida to help finance uncompensated care. These "revenue pools" are a much more recent development and their intended and unintended consequences are too recent to fully assess. In an equally preliminary way, members and staff are watching the developments in California and Arizona to see what lessons may be learned from those approaches.

The AAMC does not yet have a clear, concise, and carefully focused plan for ameliorating the problem of uncompensated care. The AAMC applauds the effort of this Subcommittee and the initiative of its chairman to highlight this serious problem and is eager to work cooperatively with others having a major interest in solving this problem.

STATEMENT OF JUDITH A. RYAN, PH.D., R.N., EXECUTIVE DIRECTOR, AMERICAN NURSES' ASSOCIATION, INC., KANSAS CITY, MO

Dr. RYAN. Mr. Chairman, I am Dr. Judith Ryan, the executive director of the American Nurses' Association. Appearing with me today is Thomas Nichols, ANA's legislative director and counsel.

We appreciate this opportunity to present the views of our 185,000 members with respect to the delivery of health care to the economically disadvantaged.

First of all, let me say that we are pleased that the subject of providing health care to the uninsured and to the poor in this country is receiving your attention. We thank you for that. Whether the problem is one of lack of access to adequate health care services on the part of the poor or one of the dilemma being experienced by providers faced with increasing numbers of persons unable to pay, or both, we must resolve the issue of how to pay for uncompensated care.

In many parts of the country, the pressures of increased competition within the health care industry are already containing costs. But cost-containment in a health and human services sector has a cost all its own. For those unable to compete for services in the marketplace, increased price competition may result in decreased access to care as providers become more and more concerned with the bottom line. If the Federal Government is committed to the marketplace as the strategy of choice to influence the utilization of health resources, we believe it must also take primary responsibility for the impact that such a strategy is having on the health needs of the disadvantaged.

We have traced in our written statement the impact that the whole changing economic environment is having on demand for nursing services, particularly those services post-discharge from hospital, and we have also traced some of the historic financing mechanisms that have been explicit to the delivery of nursing services. What we do not know is how to measure the exact extent to which various groups are being limited in their access to nursing services. We can only tell you that the broad picture is beginning to emerge, and to give you some examples:

For example, the Ramsey County Public Health Nursing Service in St. Paul, MN, a division of the Public Health Department, has provided care to the medically indigent for many years. In 1983, they averaged 702 visits per month to individuals with no reimbursement source. Thus far in 1984, they have averaged 913 visits per month to such individuals, an increase of approximately 30 percent, and the number of those patients coming without financial resources continues to increase each month.

The way in which they are financing these services is that a limited pool of funds which are provided through property taxes are providing some compensation for care delivered to those who cannot pay.

In Providence, RI, the Visiting Nursing Association sees approximately 75 cases per month who have no reimbursement source. The agency has had to find a way to limit the proportion of free care they provide. Rather than refuse referrals, they have put a cap on the number of visits an individual whose services are uncompensated may receive. In other words, they are rationing services to those who cannot pay in an effort to reduce uncompensated visits.

Seattle's King County reports that 264,500 people have received health care services in their health department and community clinics in 1984 to date, and that 60 percent of this group were uninsured. However, these health services have been made available using a combination of small grants, philanthropy, and local government dollars.

The effects of the changing health care marketplace on the disadvantaged are also being felt in the public hospital sector. That has been well documented here this morning. But nurses in our inner-city hospitals, as well as in rural facilities which serve high proportions of publicly financed or uninsured patients, report extraordinary revenue problems. And these institutions are not in any position to cover uncompensated care by recouping revenues from private pay patients because they serve a dwindling number of those patients.

The American Nurses Association believes that the Federal Government has an obligation to ensure access to essential health services for the poor and uninsured in this country. This is not to imply that the Federal Government must pay for that care in its entirety; it is to implore that the Federal Government establish and guarantee a funding mechanism—whether private or public—that will ensure access to care.

We understand that the major question is: Who will pay for this care? And how? We believe that it is the Government's role to establish a policy affirming access to needed care, which includes the definition of the appropriate public and private sector financing responsibilities.

We urge this committee, which has such broad jurisdiction over financing of health and human services, to step back and take a new look at the Federal Government's role in the delivery of health care to the indigent. We know there is no one single solution, but there seems to be a variety of strategies which the Federal Government might pursue that have been suggested here this morning, which, woven together and taken as a whole, would begin to address the potential crisis that a continuing lack of access to health care and a continuing lack of continuity in financing will engender.

We thank you for the opportunity to be with you this morning.

Senator DURENBERGER. Thank you very much.

[Dr. Ryan's written testimony follows:]

STATEMENT

of the

AMERICAN NURSES' ASSOCIATION

on

HEALTH CARE FOR THE MEDICALLY DISADVANTAGED

before the

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE
U.S. SENATE

by

DR. JUDITH A. RYAN, Ph.D., R.N.
EXECUTIVE DIRECTOR

SEPTEMBER 28, 1984

Mr. Chairman, I am Dr. Judith Ryan, Executive Director of the American Nurses' Association. Appearing with me today is Thomas Nickels, ANA's Legislative Director and Counsel. We appreciate this opportunity to present the views of the 185,000 members of our constituent state associations with respect to the delivery of health care to the economically disadvantaged.

The subject of providing health care to the uninsured and the poor in our country has received increased attention within recent months. While we do not yet know the extent of the problem, anecdotal evidence indicates that serious political questions need to be addressed at the federal level. Whether the problem is a lack of access to adequate health care by the poor, a financial dilemma experienced by hospitals faced with increased numbers unable to pay, or both, providers and policy-makers alike must be prepared to address the issue of how to pay for uncompensated care.

COMPETITION AND HEALTH CARE

Much of the policy debate about future directions of health care has focused on new ways to use the forces of the marketplace and the pressures of price competition to constrain rising health care costs. In the public sector, both federal and state governments, have taken action to gain greater control over health spending. Such actions include fundamental changes in the methods used by government to pay for health services provided to the aged, the disabled, and the poor. Governments have also encouraged wider use of alternatives to the traditional ways of delivering health services in the community. In addition, the private sector has explored new ways to use the marketplace as an effective instrument for achieving the goal of a more effective, and less costly, health delivery system.

In many parts of the country, the pressures of increasing competition within the health care industry are already being felt. Public and private purchasers of health services are increasingly concerned about the quality and the cost-effectiveness of the care hospitals, physicians and nurses provide. Major changes are occurring in the ways in which health care is being organized and financed posing new challenges for health care professionals.

However, cost containment and competition in the health care sector is not without its own cost. While the effect of market forces may hold promise for slowing health spending, there is mounting concern regarding the impact that increased price competition is having on the medically disadvantaged and others who lack access to care for financial reasons. For those whom the marketplace cannot easily serve in the competitive environment, increased price competition may result in decreased access as providers are more and more concerned with the economic bottom line. If the federal government is committed to the marketplace as the most effective way to influence the utilization of health resources, it must also take responsibility for the impact that such a strategy is having on the health needs of the disadvantaged.

THE AFFECTED POPULATION

Regrettably, we do not know the exact extent to which various groups are limited in their access to reasonable health care. We do know, however, that there is still a sizeable portion of the population that remains outside any public or private health plan.

Estimates vary on the numbers of the medically indigent and the cost of services provided to them. Even more difficult to quantify are the costs resulting from delayed treatment and the absence of preventive services. Recent data from a number of studies suggest that the range of medically indigent in the population is now from a low of five percent to a high of 12 percent. More importantly, all agree that the number and proportion of these individuals is rising.

The medically disadvantaged can be characterized as falling into a number of groups. One of the largest groups is young adults ages 18-24 who are not covered by their parents' insurance or do not secure coverage through their employment. Others have low family incomes, either slightly above or below the national poverty level. It is important to remember that Medicaid only covers 53 percent of those below the poverty line, down from 65 percent in 1979. Some lose health insurance coverage because of job loss. There are also many employed persons who have no insurance, or whose insurance does not extend to their families.

One recent study of these issues, conducted last year by the Robert Wood Johnson Foundation, confirms that lack of health insurance, compounded by low income, poses overwhelming problems for many Americans seeking health care. The evidence points to a wide disparity between the ability of those who are insured versus those who are uninsured to obtain needed health care. For example, the study found that one million families had at least one member who needed health care, but did not receive it. The Johnson Foundation Study concluded that simply to be poor in America "is no longer a major deterrent to obtaining adequate medical care -- but to be uninsured is! To be both uninsured and poor remains the most serious problem of all."

The impact of increased numbers of non-reimbursable care is already apparent. For example, the Ramsey County Public Health Nursing Service of St. Paul, Minnesota, a division of the public health department, has provided care to the medically indigent for many years. In 1983, they average 702 visits per month of individuals with no reimbursement source. Thus far in 1984, they have averaged 913 visits per month of such individuals, an increase of approximately 30 percent, and the number has been increasing each month. Clearly, we have a mounting problem as greater and greater demands are placed on providers to deliver care to those who cannot pay.

THE PROVIDER RESPONSE

The task of actually providing health services to the poor and to the uninsured falls on thousands of hospitals and health care practitioners in communities across the country. Their responses to the needs of the medically disadvantaged for medical help can and do vary widely.

Like other economic enterprises, health care providers survive only when they are in a position to recover the costs of the goods and services they produce for patients. If some segment of their business suffers losses because individuals cannot pay, or because they pay less than their actual costs, then such losses must be offset in some manner. Most voluntary community hospitals and many health practitioners subsidize this charity care burden and the bad debt experience of those who do not pay their full way by increasing the charges to patients covered by private group health insurance programs. When the burden of subsidizing the poor and the uninsured cannot then be shifted, providers of care and practitioners often respond by restricting or reducing the amount of service they are willing to supply to the medically disadvantaged.

Both governments and private employers have recently taken steps to reduce their obligations to finance health care services. The effects of these developments on the willingness or the ability of providers of health care to continue to subsidize the costs of the poor and uninsured are increasingly apparent. As the competition for paying patients intensifies, and the opportunities to shift the burdens of uncompensated care diminsh, access to care for the medically disadvantaged also becomes more restricted. Some facilities in the community will attempt to control the numbers of low-income and uninsured patients they will admit or treat. Other institutions will increase their transfers of such patients to publicly-owned hospitals or clinics. In addition, practitioners may refuse to participate in low-income health care programs or may severely limit the numbers of uninsured patients they are willing to care for.

The effects of the changing health care marketplace and the impact on the disadvantaged are being felt most acutely by the public hospital sector. Many inner-city hospitals and some rural facilities, with high proportions of publicly-financed or uninsured patients, are facing extraordinary revenue problems. These institutions are not in any position to cover uncompensated care expenses with revenues from private paying patients because they serve a dwindling number of such patients.

ADDRESSING THE PROBLEM

It is critically important that the health needs of the medically disenfranchised be served. If we do not move swiftly to address the problem, the costs of both the indigent, certain hospitals, and federal and state governments will be mammoth. While nursing has always been concerned about the health care of our disadvantaged citizens, there is an increased urgency in the new competitive environment regarding their future.

We believe that the federal government has an obligation to ensure access to essential health services for the poor of our society. This is not to imply that the federal government must pay for that care in its entirety, it is to implore that government establish and guarantee a funding mechanism, whether public or private, which will ensure access to care. The major question facing us is who will pay for the health needs of this population; we are suggesting that it is government's role to establish a policy affirming access to needed care, and including a definition of the appropriate public and private sector financing responsibilities.

There is not a single solution to this financing dilemma. It would be unrealistic to ask any one public or private entity to bear the entire burden of providing care to the indigent. Rather, there are a variety of strategies which the federal government might pursue. Taken as a whole, these fiscal strategies would begin to address the potential problems that continuing lack of care will engender.

1. The federal government must maintain an active role in encouraging hospitals to continue to provide access to care to those in the community unable to provide full payment by requiring implementation of the provision in the Social Security Amendments of 1983 which specifically grants the Secretary authority to adjust prospective payments to those hospitals with a disproportionate number of indigent patients and Part A beneficiaries.

2. Explore the possibility of public and private financial pooling arrangements to help pay for services for the medically indigent. An assessment on the net operating costs of hospitals, as in Florida, or on health insurance premiums, could help pay for uncompensated care.

3. Coverage should be increased under Medicaid to include preventive service for the poor and near-poor. Although this action will increase federal spending initially, it will pay off in the long run and reduced institutionalization. Inclusion of the Child Health Assistance Program (CHAP) in the Deficit Reduction Act this year was a positive step; increasing coverage for preventive services sould be a similar move in the right direction.

THE NURSING PERSPECTIVE

The nursing profession has a proud history of providing health care to the poor in this country. Early in this century, local government carried the brunt of financing health care to the indigent. Local and county health departments provided a broad range of public health nursing services to the aged, the poor, the chronically ill, mothers and children. Voluntary agencies supplemented these government services, and both sectors appropriated funds for public health nursing services on a prospective basis.

During the depression, nurses organized in private duty registries and began to provide care on a fee per case basis. After the depression, the concept of a third party indemnifying both patient and provider against risk of financial loss evolved, and employers found it increasingly advantageous to bargain for Blue Cross/Blue Shield benefits instead of wages as these fringe benefits were exempt from income tax. However, nurses were not recognized as providers under this new insurance mechanism, nor were nursing services recognized as covered benefits. Unable to compete in the fee for service market without insurance coverage, nurses sought employment in hospitals and other institutional care settings. With the advent of World War II, hospitals employed increasing numbers of practical and ancillary nursing personnel, and the role of the nurse as employed professional continued to evolve. The subsequent explosion of medical technology led to increasing specialization in hospital nursing practice. Nurses became salaried health professionals, and hospitals were compensated for provision of nursing services as a part of their per diem rates.

In the 1960's, the federal government acknowledged its role in insuring health care for the aged, and in sharing the cost for care of the medically indigent by enacting Medicare and Medicaid. Both programs were designed to cover essential medical services and to pay individual or institutional providers on a fee for service basis. Again, the financing mechanisms designed to pay for delivery of health services to the poor, the aged, mothers and children, failed to recognize nurses as providers. Neither did they recognize nursing services as covered benefits. Furthermore, both Medicare and Medicaid had the effect of transforming the prospective funding base for comprehensive public health nursing services, historically delivered to these populations, into a retrospective, medical-fee for service system. The system was further fragmented by the fact that only certain limited categories of persons were eligible for those services.

In the 1980's, the federal government moved to reduce the increase in federal dollars going for health care by reducing inreases in Medicare outlays; reducing increases in federal dollars going to states for Medicaid; and by shifting costs to states, municipalities, health care providers, purchasers, health insurance companies and consumers through categorical block grants, tax code changes, cost sharing, prospective payment mechanisms, and by reducing or eliminating federal dollars for targeted programs.

For the most part, the emphasis has been on cost per case reductions rather than on total system cost reductions. Furthermore, the focus of attention has been on reducing the costs for sick care, rather than on developing a health care strategy that will meet the health needs of a rapidly changing population in a cost effective manner.

It seems to the nursing profession that the aggregate effect of federal policies designed to allow market price to drive a human services system has been to drive us back in time. Lewin has estimated that there are 15 million poor and underinsured or uninsured persons, and that these persons are in generally poorer health than higher income persons of comparable age. Furthermore, these new "health poor" seem to be those same populations served by public health nurses early in this century, i.e., the aged, the chronically ill, mothers and children. While there is some uncertainty about how serious their problems are, there is growing certainty that they are getting worse.

The nursing profession's anecdotal evidence is this: Medicare's prospective payment strategies are reducing cost per case in the acute care setting. Directors of nursing tell us that the average length of stay is down. Intensity of nursing care is up. Nurses are taking care of sicker and sicker patients. Hospitals are targeting and marketing their services to the patient mix they can most profitably serve. As specialized units are closed, most hospitals are cross training experienced nursing personnel to serve in other specialized clinical areas. While most hospitals have not actually realized a deficit, management is worrying about one, and making decisions accordingly.

Nursing directors of skilled nursing facilities, nursing homes, hospices, home health agencies and community nursing services all report that they are now serving sicker patient populations, and much larger patient populations. Mothers and babies are coming home to households in which there are other children and no extended family support just hours after delivery. Patients on continuous intravenous therapy are caring for themselves at home. Cataract patients are being discharged from ambulatory surgical centers hours after surgery. Entrepreneural agencies are evolving to provide "single service" post-discharge care. They are marketing this care to the chronically ill, aged covered for "cancer care," "respiratory care," or other specific medical services. Once that patients' benefits for specific medical services have been exhausted, underfunded community nursing agencies are trying to provide uncompensated care.

The demand for skilled nursing services, post hospital discharge, is outstripping the nursing profession's ability to transfer or prepare the mix of nursing manpower appropriate to new settings and changing patient populations. This massive change poses both challenges and opportunities for nurses.

But the policy dilemma which nursing itself cannot resolve is the fragmented system for financing the delivery of the whole range of health and human services to those who simply do not have the economic wherewithal to compete for care in the market place.

The American Nurses' Association urges this committee to step back and take a new look at the federal government's role in delivery of health care to the indigent. We firmly believe that the federal government has a role. The whole history of the development of federal funding for categorical assistance programs would indicate that local and state governments are simply unable to bear the entire brunt of the cost of health and human services for certain populations.

It seems imperative that this committee, which has broad jurisdiction over health and human service programs, take a hard look at the total level of federal resources available to meet health and human need, and develop plans for a system through which all of these resources might be allocated to family units or to individuals through one appropriate unit of local government. To continue to allocate in a piecemeal way through categorical assistance programs, or to continue to patch our failing system for delivering health and human services, just will not work.

The American Nurses' Association has advocated passage of S. 410, the Community Nursing Centers Act of 1983. This bill, sponsored by Senators Inouye (D-Hawaii) and Packwood (R-Ore.) would provide a prospecively paid, community-based alternative for nursing services under the Medicare and Medicaid programs. This approach would extend the benefits of prospective payment mechanisms to community-based nursing organizations. Such entities would then be in a better position to serve the broadest possible population in need of services. While passage of S. 410 would not extend coverage to those currently lacking Medicare and Medicaid eligibility, it would make the necessary move toward eliminating barriers to direct provision of nursing services.

The nursing profession stands ready to asist the Committee in its attempt to address this growing problem. If it is not addressed adequately and quickly, we may have a situation of crisis proportion.

Senator **Durenberger**. On that latter point, a general question to the panel. And I am going to quote from the NACO testimony—and we have been through this for those of you who were here early.

> We have an indigent health care problem in this country because we have failed to resolve the tough question of responsibility. Since we have not done so, the courts are beginning to make these decisions for us. Lawsuits against counties for indigent care, common in the courts rulings against counties, are alarming.
>
> Through cost shifting and by turning away from the disenfranchised, this nation has failed to deal with the question of fiscal, legal, and moral responsibility for health care of the poor. The intergovernmental responsibility is particularly unresolved.
>
> Now, none of you were asked to address that subject specifically, but is there anyone here who disagrees with the significance of that statement as a major problem in getting to the heart of adequately providing access for the indigent to health care?

Mr. **Bromberg**. Mr. Chairman, I don't disagree with it, but I would like to change some of the emphasis. For example, I think cost shifting historically has been a good thing, and I think it's time we admitted that it may be out of date with competition, but that for years there was really nothing that terrible with a middle class or upper middle class patient paying a little more for their bill to subsidize the poor. The hospital had to do it that way, and that's the way the private hospitals did it.

I think it is also about time we recognized, on the other hand, that a public hospital is government; that's what a public hospital is, and that's what it's there for, as several witnesses have said—not just their mission, but legally that's what they are there for—and that if there was a fault historically it may be that the State and local governments didn't adequately fund it.

In a utility-type system it makes sense to send the patients there, and the Government should fund it. As we move to a price-competitive system, all the rules seem to change. For example, I applaud the statement of a prior public official here who said, "Don't give this money to the hospitals. Don't make this an institutional program."

Now, if you want to make a cost-effective delivery system out of this, maybe you give it to HMO's and maybe you give it to the States and let them decide, but the last thing in the world you should do is set up a pool of money—no matter how you get it—and say we're going to give it to the hospitals that have high charity-care loads, because they may be the wrong hospitals. It may be that a cheaper one is the one that patient should go to, and with the right incentives they would.

We used to argue about whether there is a right to health care. There are some people running around saying they have a right to patients now. They don't want their cream skimmed, like it's their cream. You know, "Don't take my cream away, my profitable patients." Well, hospitals don't have a right to patients; patients have a right to choose.

But, yes, I agree with the thrust of the urgency of the problem.

Senator **Durenberger**. Dr. Ryan.

Dr. **Ryan**. The history of public health nursing in this country would indicate that nursing has long believed that there is a government role in providing a broad spectrum of services, both health and human services, to the indigent in the local community. We believe there is a competitive role for nursing in the delivery of services in a health care marketplace in which people can compete. When we have people who continue to fall out of that marketplace, then maybe we have to go back to, upfront, prospective, governmental payment for those services to those indigent populations that we now are redefining.

Dr. **Heyssel**. Mr. Chairman, I would like to comment on cost-shifting also. As a matter of fact, that really wasn't very bad. And if you think about it, it was a reasonably broad base that that was done upon, until almost every large industry became experience-rated and really paid their costs—whether they were through a Blue Cross payor or not. As long as there was some community rating out there, the facts of the matter are that everybody in the State bought a piece of the action for the costs of graduate education, for uncompensated care, and so forth, wherever it occurred.

The moment we had the competitive market and everybody opting out on price, that changed dramatically. And you can't support the system we have any longer, increasingly, through cost-shifting. We must find another way to do it.

I want to make one other point. I agree with my friend Mr. Bromberg that my cream is what he wants. [Laughter.]

The problem is, I'm not sure he does.

Senator **Durenberger**. I would have to agree with that, too. [Laughter.]

Even I'll agree with that.

Dr. **Heyssel**. The problem is, I'm not sure he is; because while it has been said that the major burden is the public teaching hospital—and an article was published by Frank Slone and colleagues from Vanderbilt that said that basically that's where the charity was in teaching hospitals—that's not totally true. The bad debts that we have are concentrated in neonatal intensive care units, in trauma care, and those special services we provide.

You know, those special services are things that society has decided they wanted available, and that they should not be available in every hospital, and they ought to be put in the hospitals that can really do it.

Now, maybe we need to find a way to fund what I would call partly firehouse functions and standby functions through a different mechanism, as another example. But it isn't true that teaching hospitals' problems are simply because they can't collect their bills; it is because you can't collect bills from people who can't pay it. That's the problem.

Senator **Durenberger**. Bob, I'll give you the last word on this.

Mr. **Johnson**. I just want to say that, as everyone has said, it has been a hidden tax. I think the Federal Government in 1965 stepped up to bat for a segment of the poor in this country and said that it is a national responsibility. I think it is fair to say the care for the poor is a national, State, and local responsibility. It ought to be paid from the broadest tax base.

It is clear, though, that it should not be left exclusively to the communities that happen to be, by circumstance, the places where the poor live to home should the financial cost of paying for the care of the poor. Why should the cost of taxes of the residents of this city be so much higher because there coincidentally happens to be a large number of poor people in this city? It has got to be fair, and it's not fair to simply say it's a local problem; this problem requires the broadest base of taxing. It has to be a shared responsibility, but it certainly ought to be broader than simply the local jurisdiction.

Senator DURENBERGER. I need to ask you a question that I think relates back to something that both Mike and Judy said. I think I heard in your oral testimony that you are exploring an HMO.

Mr. JOHNSON. Yes, Senator.

Senator DURENBERGER. Now, you and I live in a town in which I have lists this long to choose from, among which are HMO's. Why, on behalf of the indigent or with the help of the indigent, are we not buying from existing HMO's—services in your facility or other facilities?

Mr. JOHNSON. There is a small amount of that being done, and I'm not sure I can answer from the point of view of the State agency, only from the perspective of an institution. We believe that we need to develop strategies that allow us to serve the population better, broaden the number of patients that we serve, to find ways to control costs but also stay financially viable, so that we are interested in it purely as survival strategy as well as better provision of care to the Medicaid population strategy.

Senator DURENBERGER. But what I hear you say is that you wouldn't agree what some of these other people said, "Let's cut off financing the institutions and start financing the people." Because you have a survival problem.

Mr. JOHNSON. I think we have a short- and long-term problem. I think in a way one could argue that if you get past the point where everyone is covered, and reasonable controls are there so that it is not so competitive that you do away with good institutions that have traditionally served the poor and have a concentration of technology then you can focus on simply providing individual coverage in the long run ability to pay for care should be assumed for all citizens that is, you give a person the ability to seek care, I think that is the better choice. In a way, it shouldn't be just institutions' preservation.

In the short run, we've got to stay in business to continue to provide service.

Senator DURENBERGER. Is there any reason why, here, this isn't getting going? I mean, people are experimenting with gatekeeper programs and exploring some HMO alternatives. Is it happening around here, or isn't it? What is the problem?

Larry, do you want to respond to that?

Mr. GAGE. Yes, if I can respond to that, I think that the answer is that it is happening, and beginning to happen in several parts of the country. I think you are up against the classic problem, the totology that there may not be enough money to buy even the level of benefits that are provided in a piecemeal basis in many Medicaid Programs on a capitated basis.

One of the problems that HMO's Medicaid Programs have had in purchasing capitated services from existing HMO's in some States is that they can't pay a high enough premium to genuinely save money. And so to design an institutional package or an HMO that can be tailored to either the Medicaid benefit package or sold to indigent persons at a reasonable cost requires a great deal of creativity. I think this is being done. I think among the many competitive elements in the system, the only one that I think stands even a moderate chance of assisting low-income people is the HMO or the capitated model. We are exploring it.

Senator DURENBERGER. We have to keep moving on behalf of the other witnesses, but let me ask you and Mr. Newman a question.: How is the public hospital in America changing? I have seen somewhere the hospital is just a building, and it got put up there by the county commissioners and the State legislature, and that's it—that's what we call a "public hospital." But I have seen others who have sort of taken a look at themselves and said some of these things shouldn't be done in a hospital but should be done somewhere else, so they are buying primary care outside the hospital so people aren't using the expensive emergency rooms, they are buying services from other hospitals where that is appropriate.

How is the public hospital in America changing to meet some of the pressures of the high cost of delivering services in those buildings?

Mr. NEWMAN. Senator, it is going to run the range of several activities, not only under the general rubric of competition, because we need to compete just like anybody else. It's true, our mandate is to serve the poor; but we also have the availability to serve other patients.

We are exploring with existing HMO's to distribute patients on an outpatient and ambulatory care basis within the community, and to do it on a per-capita basis. It probably is going to be less than what we can provide within our own institution. No 1, we have access capacity unavailable in order to meet the increasing demands, because our volume has been going up while everybody else's has been going down.

We are also contracting with outlying counties to provide services that they do not have within their own counties. We were the ones that started suing other counties, because we would send them bills for their indigent patients and they would not even talk with us about paying it. Now that we have won the first two or three lawsuits it's amazing how the attitude has changed and they are willing to communicate with us.

Texas is very active with a State Governor-appointed task force to look at indigent care. The task force is reporting out later this month on its recommendations, because it's recognized that it is a problem.

We want to use those things that are competitive in nature as well as looking at utilizing the resources we have available. In many cases we can provide services better than other hospitals can, and if hospitals have the excess capacity to sell, we've got several of those contracts, and I think it is going to improve our situation without increasing the tax burden that has to be spread around.

Senator DURENBERGER. Thank you all for your testimony; I appreciate it.

The next panel consists of Mary Nell Lehnard, vice president, Blue Cross and Blue Shield of Washington; Eugene Barone, president of Blue Cross of western Pennsylvania; and Leona Butler, vice president of public and provider affairs for Blue Cross of California.

All of your statements will be made part of the record, and if you can keep within the 3-minute limitation it will certainly be appreciated.

STATEMENT OF MARY NELL LEHNARD, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Ms. **Lehnard**. Senator Durenberger, I am Mary Nell Lehnard, vice president for government relations for Blue Cross and Blue Shield Association. With me today are representatives from two Blue Cross plans—Blue Cross of western Pennsylvania, and Blue Cross of California.

Like everyone else today, we are very pleased that you are holding these hearings. We think it's necessary and timely to explore the whole issue of who is going to finance health care for the economically disadvantaged.

We are also pleased to be able to share some of our local programs that individual Blue Cross and Blue Shield plans have developed in response to this problem. We think that Blue Cross and Blue Shield plans and their subscribers have contributed significantly to funding care for the economically disadvantaged: First by making health insurance coverage broadly based, readily available, and as affordable as possible; second, by developing special programs for the unemployed and others; and, third, by reimbursing hospitals through a variety of payment mechanisms for a significant share of the cost of uncompensated care.

With me today is Gene Barone, president of Blue Cross of western Pennsylvania, who will address the ways that his plan deals with the various problems faced by the economically disadvantaged, including their program of health insurance for the unemployed.

Also with me is Leona Butler, vice president of public and provider affairs for Blue Cross of California. She will explain how that plan's contract negotiations with individual hospitals under its preferred provider arrangement considers the hospitals' cost of uncompensated care.

Senator **Durenberger**. Mr. Barone?

[Ms. Lehnard's written testimony follows:]

TESTIMONY
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

BEFORE THE
SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

PRESENTED BY

MARY NELL LEHNHARD
VICE PRESIDENT
OFFICE OF GOVERNMENT RELATIONS

SEPTEMBER 28, 1984

I am Mary Nell Lehnhard, Vice President of the Office of Government Relations of the Blue Cross and Blue Shield Association, and with me today are representatives of two Blue Cross Plans — Blue Cross of Western Pennsylvania and Blue Cross of California. We appreciate this opportunity for these Member Plans to present testimony on the delivery of health care to the economically disadvantaged.

The issue of ensuring access to needed health care for the economically disadvantaged, that is, low income persons who have no health insurance and are ineligible for Medicaid, is of concern to all sectors of the health care marketplace. There are a variety of programs in place or under development which are a direct response to this problem. We are pleased to be able to share some of the local programs that individual Blue Cross and Blue Shield Plans have developed.

We commend the Subcommittee for holding these hearings. We believe it is necessary and timely for the issue of financing care for the economically disadvantaged to be explored.

As you review the effectiveness of existing programs and the need for additional initiatives, we would urge you to keep in mind that the private sector is already providing a significant level of funding for health care for the economically disadvantaged. The programs you will hear about today, in fact, demonstrate this. To date, Blue Cross and Blue Shield Plans and their subscribers have contributed significantly to this funding by: (1) making health insurance coverage broadly based, readily available and as inexpensive as possible; (2) developing special programs for the unemployed and others; and (3) reimbursing hospitals through a variety of payment mechanisms for a significant share of the cost of uncompensated care.

The Association will have more general comments when we testify at the Committee's hearing on proposed solutions to the uncompensated care problem.

With me today is Eugene Barone, President of Blue Cross of Western Pennsylvania, who will address the various ways that his Plan deals with the problems faced by the economically disadvantaged, including its successful program of health insurance for the unemployed. Also with me is Leona Butler, Vice President of Public and Provider Affairs for Blue Cross of California. She will explain how that Plan's contract negotiations with hospitals under its innovative Preferred Provider Arrangement considers a hospital's costs of uncompensated care.

STATEMENT OF EUGENE BARONE, PRESIDENT, BLUE CROSS OF WESTERN PENNSYLVANIA

Mr. **Barone**. I am Eugene J. Barone. I am president of Blue Cross of western Pennsylvania, with headquarters in Pittsburgh, and I will briefly summarize, Senator, the written statement that is submitted for the record.

The mission of Blue Cross and Blue Shield is to make coverage available to all segments of the population. And that includes the health disadvantaged as well as the economically disadvantaged. As an example, the high level of unemployment that we have been experiencing in western Pennsylvania created a special need for health care coverage. In the early part of 1983 we developed and offered a program to the unemployed. It was a specially designed program, and we were very pleased that the 96 participating hospitals of western Pennsylvania participated in this program. As we were attempting to develop a rate as low as we could get, the hospitals agreed to subsidize the premium rate by 20 percent. Blue Cross in turn subsidized an additional 20 percent, and also subsidized the administrative and the promotional aspects of the program.

Pennsylvania Blue Shield and its participating physicians in western Pennsylvania also cooperated and offered a medical/surgical program to the unemployed—again heavily subsidized.

We have offered the program since 1983—May 1 was the effective date of coverage. Since then we widely publicized open enrollments of this coverage. In fact, we are in the midst of one now, an open enrollment that we have gone into heavily in unemployed areas and attempted to work with groups in that area to find the unemployed.

Today there are approximately 17,000 people covered under this program, and over the past year approximately 35,000 people participated in it. Since then, of course, many of these people have returned to the work rolls and are covered under their existing programs.

What surprised and pleased us not just the success of the program, but that it verified and strengthened our community-service philosophy, in that we found—though there were a lot of skeptics at the beginning of the program—that many people wanted to maintain their dignity and independence, and found a way of paying the premium for this program.

In fact, we are now developing a similar program for the marginally employed people.

So the message today is that we still carry on our principles of operation that the founders of our corporation developed back in 1937, and that's to provide coverage to all segments, continuity of coverage for life—we don't cancel for high usage—the subsidized rates for the disadvantaged segments. And because of these programs—and they require, by the way, cooperation of providers and the general public—the free care burden in western Pennsylvania hospitals decreased from 43 percent when we went into operation to the present 2 to 3 percent.

And the ability to achieve balance between the need for health care services and the ability to pay for those services has been derived from two mechanisms: One is the hospital reimbursement agreement we have, that pays on the basis of audited costs rather than charges, and the second is the surcharge on rates that we charge to groups that we refer to and identify for the groups as a "community service factor." And with this fund we help to subsidize coverage for disadvantaged segments.

So our aim is to continue to pursue the special challenges of meeting the care financing needs of the disadvantaged, and we are confident that the voluntary and community efforts will continue to play substantial roles in meeting the health care needs of the people.

Thank you.

Senator DURENBERGER. Thank you very much.

Leona Butler?

[Mr. Barone's written testimony follows:]

TESTIMONY
OF
BLUE CROSS OF WESTERN PENNSYLVANIA

BEFORE THE
SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

PRESENTED BY

EUGENE J. BARONE
PRESIDENT
BLUE CROSS OF WESTERN PENNSYLVANIA

SEPTEMBER 28, 1984

Mr. Chairman and honorable members of the Subcommittee on Health of the Senate Committee on Finance, I am Eugene J. Barone, President of Blue Cross of Western Pennsylvania, with headquarters in Pittsburgh. Thank you for this opportunity to address the subject of health care coverage for the economically disadvantaged.

Although I will be commenting primarily on the history and operations of the Blue Cross Plan which I represent, it should be understood that our record of service is typical of the Blue Cross and Blue Shield Plans serving the people of Pennsylvania and of many other Plans in the nation.

Early in 1937, the Pennsylvania legislature adopted the Non-Profit Hospital Plan Act — a statute which recognized the potential public good of a voluntary, non-profit approach to meeting the health care financing needs of community members. Pennsylvania was the fourth state in the nation to take such action, and Blue Cross of Western Pennsylvania, chartered in the Fall of 1937, became Pennsylvania's first non-profit hospital service corporation.

Utilizing a fund of $20,000 advanced by the Buhl Foundation of Pittsburgh, Blue Cross of Western Pennsylvania became operational on January 1, 1938. Within two years, the Plan had repaid the $20,000 loan, and had enrolled more than 200,000 subscribers — an enrollment size established in late 1937 as the probable maximum that could ever be attained. Today, our Corporation provides protection for more than 2,600,000 residents in our 29-county service area.

With the Corporation's historical roots based in the Depression days of the 1930's, the founders of our Plan recognized the unmet needs of the people, and the importance of developing a program of health care benefits that would effectively remove the barrier between need for care and ability to pay the attendant costs. With remarkable foresight, they also recognized the similarity of need between those disadvantaged by economic conditions and those disadvantaged by conditions of health. They further observed the direct correlation between age and the usage of health care services. As a result, the first program of coverage offered by our Plan on January 1, 1938 provided for continuity of coverage for life, a guarantee against cancellation because of utilization of services and, through the community-rating principle, the same rates for all regardless of age, sex or other demographic characteristics.

With the evolution of the health care industry, accompanied by rapidly increasing competition in the health insurance market, benefit programs and rating principles have necessarily changed. But those original assurances of continuity of coverage, non-cancellation for high usage and subsidized rates for the disadvantaged segments of the community are still in place today. And they continue to function with remarkable effectiveness.

Another goal of the founders of our Corporation — the availability of coverage for all without regard to age, employment status, or condition of health — could not be fully achieved for a number of years. But, with a constancy of Corporate purpose and philosophy, progress was continuous and the goal was reached.

Our 1938 protection program was designed for employed individuals and their dependents. But if the employee lost his or her job, became disabled or retired, coverage was continued on a direct payment basis. If the employee died, coverage for the dependent spouse and children was continued on a direct payment basis. Although the applicant for coverage had to be under 65 years of age at the time of enrollment, continuity of coverage for life was guaranteed.

In 1946, our Corporation had gained sufficient experience and financial stability to begin offering a program of non-group benefits. Full service coverage (days of care regardless of the number or cost of the health care services required) was provided to non-group subscribers just as it was to group subscribers. And although non-group coverage was subject to medical underwriting at the time of enrollment, there again was assurance of lifetime protection without regard to subsequent deterioration of health or extensive need for benefits.

Throughout the 1940's and 1950's, benefit programs for both group and non-group subscribers were expanded. Coverage of nervous and mental disorders became a standard inclusion. Benefits for treatment of alcoholism, drug addiction, physical rehabilitation and inpatient dental care were added. And protection programs were expanded to include a wide range of outpatient services.

In 1961, Blue Cross of Western Pennsylvania took another major step toward its goal of coverage for all. A Senior Citizen Agreement was developed and offered to all persons age 65 and older who had not been covered by Blue Cross prior to age 65.

Two years later — in 1963 — The Corporation's goal was reached with the introduction of our Non-Group Special Program. This agreement provided protection to all those otherwise unable to obtain coverage due to age, illness or other disability. No health questionnaire, no medical examination, no medical underwriting of any nature was required. The agreement simply included a 12-month waiting period for pre-existing conditions, after which the coverage became totally unrestricted — and again in terms of full days of care.

It was in 1963, then, that the Corporate goal of our Blue Cross Plan was fully achieved. Comprehensive health care protection was available to every resident of Western Pennsylvania without regard to age, condition of health or employment status.

When Medicare became effective on July 1, 1966, our Plan was providing basic coverage to approximately 200,000 Western Pennsylvania residents age 65 and older. Benefits being provided to these older persons equated to $2.00 in costs for each $1.00 received in subscription rates.

It is also important to note that the Plan's determination to make coverage available to all had a salutory effect on the financial stability of Western Pennsylvania hospitals. With the advent and growth of Blue Cross, the free care burden of voluntary hospitals in Western Pennsylvania decreased from 43 percent in 1937 to 14 percent in 1966. (With Medicare and Medicaid in place, free care now averages between 2 and 3 percent.)

The introduction of Medicare obviously required concurrent changes in Blue Cross coverage for the elderly. The primacy of Medicare coverage obviated the need for Blue Cross basic benefits. Hence, complementary Blue Cross coverage was designed to fill in coinsurance and deductible needs, and to extend benefits beyond the Medicare limits. This complementary coverage was, and continues to be, offered to all Medicare beneficiaries, including the disabled, regardless of age. Our pay-out ratio for this complementary coverage over the past 18 years has been $1.09 for each $1.00 received.

The Corporation's historical record of achieving reasonable balance between need for health care services and ability to pay has been derived, in the main, through two mechanisms: negotiated hospital reimbursement agreements approved by the Pennsylvania Insurance Department with payment based on audited hospital costs (and, in more recent years, plus factors added to costs to compensate for unreimbursed care provided by hospitals and other community service work performed); and a premium surcharge to all group accounts (with the exception of small community-rated groups) clearly designated by our Plan as a community service rating factor.

This purposeful subsidization of coverage for disadvantaged segments of the community — the elderly, unemployed, disabled and others limited by income or health in the non-group and small group (2 to 10 employees) categories — has enabled our Blue Cross Plan to provide meaningful coverage to many thousands of people who would, by commercial insurance company standards, be considered uninsurable. This voluntary, non-profit approach also has enabled these Western Pennsylvania residents to remain self-sufficient with regard to their health care needs, to be relieved of the fear of potentially devastating debt when illness or injury strikes, and to enjoy the capacity of seeking medical treatment at the onset of illness rather than waiting until the condition is severe.

To achieve this public good, our Blue Cross Plan and its subscribers have provided a cumulative subsidy of nearly $150 million.

During 1983, Blue Cross of Western Pennsylvania again demonstrated its acceptance of community obligation by developing a pioneering program for the provision of health care coverage for unemployed Western Pennsylvanians.

This special program of coverage for the unemployed first became effective on May 1, 1983. There have been four widely-advertised enrollment periods — the most recent of which will end next Monday, October 1st. Although we had originally thought that a one-year duration for the program would meet this special need, the continuing high unemployment levels in various parts of Western Pennsylvania have convinced us to keep the coverage in force through September, 1985.

With the cooperation of all of our Western Pennsylvania community hospitals, this special program is offered to the unemployed at a combined Blue Cross-hospital subsidy in excess of 40 percent. Pennsylvania Blue Shield and its participating physicians have cooperated fully with us in providing for the unemployed a highly subsidized companion program of medical and surgical benefits.

At the present time, about 17,000 people are covered under this special program. Nearly 35,000 people, however, have benefitted from this effort since many enrollees subsequently became re-employed and returned to our regular programs of coverage.

Here again, I wish to point out that our concern for the unemployed was shared, and responded to, by other Pennsylvania Plans and by Plans in other parts of the nation.

As we continue our efforts to serve the Western Pennsylvania community, we shall seek new opportunities to provide meaningful health care protection to all segments of the population. Holding steadfast to our Corporate philosophy and our historical practices, we shall continue to pursue the special challenges of meeting the health care financing needs of the disadvantaged members of society. In so doing, we are confident that we can also continue our progress to date in helping to shape a more efficient and economical health care system. We are equally confident that voluntary, community effort — so much a tradition in this country — will continue to play a substantial role in meeting the health care needs of the people.

Thank you for the opportunity to present these comments.

STATEMENT OF LEONA BUTLER, VICE PRESIDENT OF PUBLIC AND PROVIDER AFFAIRS, BLUE CROSS OF CALIFORNIA

Ms. BUTLER. Thank you.

In my capacity with Blue Cross of California as vice president, I am responsible for contracts with hospitals and physicians, both for our standard programs and for our new preferred provider type of option. When the competitive experiment on a grand scale was implemented in California through State legislation, there was much concern expressed similar to concern you heard here today, particularly the kind of concern from Mr. Johnson that said, "What's going to happen with the teaching hospitals? What is going to happen in the competitive model with the county institutions? How are we going to continue to finance indigent care, uncompensated care?"

Blue Cross of California, which really set a model which others are now following, in implementing a preferred provider option in the State, took that into account in such a way that we believe, today at least, is showing not only can uncompensated care be taken into account and dealt with but as a matter of fact can be dealt with to the advantage of everyone concerned.

As we engaged in a competitive model of selective contracting—that is, an open bidding process—allowing all hospitals in a given area to present a proposal to us, to bid with us, we then, in selecting what we estimated would be approximately one-third of the hospital beds in any given area, set about looking at not only the competitive price which was being offered to us but a number of other factors, in fact we developed a computer model enabling us to adjust our decisionmaking based on weighted factors other than price. Those factors included the amount of uncompensated care being given—very specifically, bad debt, charity care—and took into account also the percentage of a hospital's Medicare population, its Medicaid population, and obviously such other factors as the current cost of the hospital, the percentage of increased costs in the hospital, and access, and of course the scope of services of the institution, giving greater weight to those institutions with the more tertiary kinds of services such as burn, neonatal intensive care, and so on.

I am very pleased to say that when my testimony was prepared we had contracted with 172 hospitals. We actually have now added 6 more since that time, so we now have completed 178 contracts. Of those, 14 are with teaching hospitals—that's 14 of the State's total of 21 teaching hospitals—and three are with county institutions, institutions that people didn't believe we would be able to contract with at all in the competitive model. Additionally, we contracted with numerous—too numerous to have counted—inner city hospitals

Interestingly, we have managed that and have achieved for the first year a 23-percent reduction in payments to hospitals as a result of this contracting, and in our second year now have seen a reduction of 28 percent—an additional 5 percent—maintaining those same teaching hospitals, county hospitals, and in fact adding some.

I believe it speaks to the fact that there can be taken into account in the competitive model the indigent care provided, and it can still be cost effective. It must be understood, however, that in California we have a tremendous surplus of beds. More than 40 percent of our beds are vacant. The extent to which a carrier, and for that fact any payor such as the Medicaid or Medicare Programs can help a hospital to fill its beds through patient channeling, is the extent to which that hospital can operate more effectively, efficiently, and at a lower cost, incrementally, for every patient.

Now, that means eventually some hospitals are going to close. The major issue before us today in California is how is it going to be determined which of those hospitals will no longer be viable.

My written testimony I think has quite a bit of data that supports what I have been saying.

Senator DURENBERGER. I have marked it up already. It is very interesting.

[Ms. Butler's written testimony follows:]

TESTIMONY
OF
BLUE CROSS OF CALIFORNIA

BEFORE THE
SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH

PRESENTED BY

LEONA BUTLER
VICE PRESIDENT OF PUBLIC AND PROVIDER AFFAIRS
BLUE CROSS OF CALIFORNIA

SEPTEMBER 28, 1984

Mr. Chairman and members of the Subcommittee on Health of the Senate Committee on Finance, I am Leona Butler, Vice President of Public and Provider Affairs of Blue Cross of California. I appreciate the opportunity to appear before you to speak about what Blue Cross is doing, on its part, to address the serious issue of provision of uncompensated care in the hospitals of our state. As Vice President of Blue Cross, among my major responsibilities is the negotiation, establishment and maintenance of Blue Cross contracts with hospitals and physicians. This includes both contracts for our standard fee-for-service health care coverage and for alternative health programs, particularly our preferred provider option — the Prudent Buyer Plan.

To place our approach in perspective, it is necessary to briefly profile the health care delivery environment in California today:

1.	Number of California hospitals:	511	
2.	Number of available, licensed hospital beds:	89,769	
3.	Occupancy rate (general acute care, 1983):	59.1%	
4.	Physician surplus:		
	A. Number of physicians, metropolitan areas:	55,651	
	B. Number of physicians, rural areas:	1,574	
	Total (December, 1982)		57,255
	C. Estimated need (based on 190 per 100,000 pop.)		46,930
	Physician surplus in California (1982)		10,295 (18%)
5.	California population (July, 1982):	24,724,000	
6.	Medicare population (July, 1982):	2,457,937	
	Medicaid (Medi-Cal) population (1983)	2,804,720	

7. Hospital profile — revenue, bad debts, charity care (July, 1981 - June, 1982):

Hospital Type	Gross Patient Revenue	Bad Debts	Charity Care	Total Uncompensated Care	Total Uncompensated Care as a Percent of Revenue
County	$1,447,908,250	142,764,783	117,442,010	260,206,783	18.0%
District	884,192,865	22,551,191	1,937,327	24,488,518	2.8%
Investor-Owned	2,533,687,570	68,541,951	626,154	68,168,105	2.9%
Non-Profit	7,772,233,303	181,242,668	58,627,418	239,870,086	3.0%
TOTALS	**$12,638,021,988**	**415,100,593**	**178,632,909**	**593,733,502**	**4.69%**

8. Hospital closings:

Last year:	No closings, two hospitals shifted from General Acute Care to Psychiatric Care
Last 8 years:	12 hospitals closed doors
	13 hospitals merged, were absorbed, changed services, etc.

To summarize, in California we have too many acute care beds, too many physicians, too many indigents who are not eligible for Medicare or Medicaid (called Medi-Cal in California) and too few hospitals willing or able to meet the needs of the many poor who are ineligible for entitlement programs. Additionally, acute care in California is among the costliest in the nation, with a bill for one day in the hospital now averaging $809, according to the California Health Facilities Commission. This is an increase of 216 percent in the 10 years since 1974. If hospital charges were to continue to escalate at this rate, 10 years from now, in 1994, the average one-day stay in a California hospital would be $1,747.

Obviously, something had to be done to slow this astonishing rate of increase — an increase experienced also by the state's Medi-Cal program, with a $4 billion budget for health care of the poor. For the previous 11 years, members of the state legislature had been trying to enact some form of hospital rate regulation, but always with the same lack of success. There was simply not enough belief in the effectiveness of the regulatory process to gain the necessary leadership support, particularly over the opposition of the medical industry.

In 1982, however, another approach was tried, one which captured the imagination of business, labor, the insurance industry, the state legislature and consumer representatives, who coalesced around the idea of controlling costs through competition rather than regulation. The approach of selective contracting by the state with hospitals for the Medi-Cal program and selective contracting by insurance companies with hospitals and physicians for the private sector was thereby enacted into California law. Much concern was expressed at that time over what would happen to uncompensated care as a result of selective contracting. There was fear that this new competitive environment, combined with changes then pending in Medicare reimbursement, would force hospitals to discontinue their needed but poorly reimbursed services, to concentrate upon those services found to be most profitable in the marketplace.

If, for example, an obstetrics service was not paying for itself — particularly if this were true because of heavy utilization by California's undocumented workers — then the hospital might simply discontinue this service and "let them go somewhere else."

There was, also, a very well based concern that the state's county and teaching hospitals would simply not be able to "compete," particularly in a competitive bidding process, and would thereby be unable to contract either for the Medi-Cal program or for private care, thereby leaving these hospitals with little source of outside revenue but the continued obligation to provide health care to anyone in need.

While I am not here to speak about Medi-Cal contracting, it is of value to note that of the state's 31 county hospitals, 21 received Medi-Cal contracts. Of the state's 21 teaching hospitals, all have received Medi-Cal contracts. In California, we have seen no evidence that selective contracting has had any adverse effects on access to care for the economically disadvantaged.

When the competitive legislation passed in California in 1982, Blue Cross of California moved quickly to establish a preferred provider option based on selective contracting with hospitals and physicians in the marketplace. It made available, to both groups and individuals, a more affordable form of health care coverage, one which would include the ability to control future rate increases as well as reduce current costs. We came to call this approach the Prudent Buyer Plan.

We started our contracting process in April, 1983 and now have contracts with 172 hospitals and over 12,000 physicians. This represents slightly more than one-third of the hospital beds, and one-fourth of the private practicing physicians in the state. This program is now covering the health care needs of over 350 employee groups and we expect our membership to total over one-half million people by year's end, including individually enrolled members who are being phased into the program. It was first available in the marketplace in October, 1983 on a limited basis, and on a wider scale in January, 1984.

I believe of particular relevance to this Committee's inquiry is the process and criteria we used in our selective hospital contracting. We contracted in the state on an area-by-area basis, using state designated "health facility planning areas" as appropriate geographic units for contracting. The state is divided into 137 health facility planning areas (HFPA). For instance, the city of San Francisco is designated as one HFPA.

As we were ready to contract in an area, we wrote to all hospitals in that HFPA explaining our approach and offering what in effect was a request for proposal. We asked each hospital not only for a per diem price for care of Prudent Buyer Plan members, but also for considerable descriptive material, including data on occupancy, bed capacity, Medicare status, Medi-Cal status and occupancy, and extent of indigent care. As this information was received from each hospital, we incorporated it with data from the California Health Facilities Commission, the state's hospital data collection agency, to develop a specific profile for each hospital. This profile includes such information as bad debt write-off, assets to liabilities ratios, long-term debt, and source of payment by type of service.

As we began negotiating, and then finalizing contracts with hospitals in the area, this and similar data relating to Blue Cross current utilization and payments was taken heavily into account.

To make the process as fair and equitable as possible, we developed a computer model which has enabled us to balance price decisions against the other criteria we considered to be important. As a non-profit organization, we have believed, and continue to believe, that significant price differentials can be achieved competitively without sacrifice of other health care objectives. Our computer model has enabled us to consider in our selection process those other important elements, such as whether a hospital is a teaching institution, the extent of community service provided by the institution, including uncompensated care, and its importance to the Medicare and Medi-Cal programs.

These factors were heavily weighted in our selection process. Obviously, other factors as well have been important to us — particularly the rate of increase in hospital charges in the last few years, the amount of Blue Cross patient utilization within the hospital, the scope of services of the institution, and patient access. The model we developed has enabled us to include these "non-price" or qualitative factors as at least one-third of our decisions as to which hospitals would be offered contracts.

I believe results to date speak for themselves. We have contracted with numerous inner-city hospitals, 13 teaching hospitals, and 3 county hospitals. Combined, these are the institutions to which the indigents have looked and continue to look for care.

We are now in the process of completing our second year's contracting and I am very proud to say that there is only one hospital with which we are discontinuing our contract, a hospital which falls into none of the above categories and with which we have been unable to come to terms, most probably because of a change in ownership.

In order to understand why a hospital which provides a significant amount of uncompensated care can be competitive in Blue Cross contracting, it is necessary to remember the occupancy in California to which I pointed earlier. Over 40 percent of the available beds in the state are empty. We believe, and our results to date have verified, that the extent to which we can help a hospital fill its beds is the extent to which a hospital can operate efficiently, with maximum utilization of resources, and thereby remain competitive.

A hospital has certain fixed costs which continue whether or not beds are occupied: the cost of the plant itself, equipment, debt service, and to a certain extent staffing continues whether or not its beds are full. Through selective contracting, as the hospital fills its beds because of incentives offered to patients to use a contracting hospital, the hospital is able to meet its fixed costs and achieve more efficient utilization as it incrementally adds staff to care for its additional patient load.

The actual hospital costs per patient decrease considerably as the patient load increases. We believe, therefore, that uncompensated care can be "compensated" in the competitive environment if a hospital is assisted in reasonably filling its beds and in having a reasonable proportion of private pay patients.

The payment mechanisms we employ in our standard fee-for-service coverage also help to finance hospitals' uncompensated care costs. For example, our contracts with hospitals in Southern California involve cost-based reimbursement that includes consideration of allowances for bad debt and charity care.

Clearly, there are some hospitals which are simply not going to be able to attract private pay patients because of long-standing community perceptions about "charity" hospitals. This is not a new problem nor is it one which either competition or regulation can solve.

Obviously, as we begin to see the results of competition in California, serious issues remain open. If, for instance, selective contracting and the resulting patient channeling works on a wide scale, there will be those hospitals which have not been able to effect public or private contracts. Undoubtedly, if selective contracting works, some hospitals without contracts will be unable to remain economically viable and some hospitals will be forced to close. Which hospitals will those be? This must be carefully monitored. Are there mechanisms which should be offered to appropriate hospitals, to enable them to convert to more necessary services such as the provision of long-term care? How will we finance the care provided in the "charity" hospitals which simply will not be able to attract private patients?

Thank you for the opportunity to present these comments.

Senator **Durenberger**. Well, thank you all very much.

On the issue of some hospitals closing—and we have heard that before today, and usually it is the high-cost hospitals, the inner-city hospitals, the one with the highest number of indigent and bad debt, and/or they are small and they are rural.

That gets me to the point of, as you start doing medical contracting, and so forth, to get a definition of access for the indigent, where does the—I'm not going to say this right—the "geographic factor" come in? I keep hearing that you can't let these large inner city hospitals die. And yet, out in the country people will travel many, many miles in different directions to get different kinds of care. It strikes me that it is less expensive to set up some kind of either primary care or some other kind of unit, like a gatekeeper approach of some kind, and then a less expensive transportation system. But they insist that we keep $809 a day hospitals or $1,000 a day hospitals going in this particular area.

Now, I am not taking that position. I am just suggesting that there is something in here that needs to be examined. You cannot take out all of your hospitals from your inner-city area; and yet, I look at my own community and the communities that I travel in across this country, and everybody's downtown. We have sort of enfranchised that with the health planning system so that we are making sure that they don't grow up somewhere else. But the largest part of the overbedding seems to be in the so-called inner-city.

I am getting too far from my question. The question is, can you help us define, when there are restrictions on freedom of choice and somebody else is starting to make the which hospital do you go to decisions for the indigent, in defining access where does this proximity thing fall?

Ms. **Butler**. Yes. Let me use San Francisco as an example; it's a good geographic area to talk about. San Francisco has 14 acute-care hospitals, about 1,200 too many beds. We did some actual market research to look at, in an employer community, what is an acceptable distance to travel. And this was with somebody buying insurance, paying a premium. How far will they travel for a reduced premium? What is the distance that is acceptable? And we found in an urban area 10 miles was very acceptable, for people to travel 10 miles.

Now, that depends on where you are. In Los Angeles, 10 miles might take more than half an hour, then it's unacceptable. But a half an hour's worth of travel or 20 minutes worth of travel is very acceptable to go for care. As to San Francisco, you can go anywhere in San Francisco in a van or a bus or a car in 20 minutes to half an hour. The hospitals that are inner city hospitals are all lumped together within a 2-mile radius.

So the argument that is often presented about access, keeping them all open, is obviously something that needs to be questioned.

However, what also needs to be taken into account is the public's current patterns of getting care. A very specific example: In LA County, when Martin Luther King Hospital was opened in the Watts area they had a terrible time getting patients there. Patients were more used to traveling out to USC–LA County Hospital, and they would continue to do it even though Martin Luther King Hospital was far closer, provided better access, but it's not where people were used to going. So the patterns of where people are going to obtain care must be taken into account.

Many of the more enlightened inner city hospitals are now beginning to do van services, so that they are going out and picking up and delivering people. This is especially important for the elderly poor.

That's not giving you a lot of enlightenment, but some.

Mr. **Barone**. Senator, we find in our area many of the inner city hospitals are entering into arrangements with the rural hospitals, and the rural hospitals are becoming more short-term type institutions and then referring longer term stays to the inner hospitals. There is a move to do that extensively in western Pennsylvania.

People out in the rural areas are accustomed to travel for everything.

Senator **Durenberger**. But even that is changing. Well, I don't want to explore this too much now.

There was a mention earlier on of Select Care in Baltimore and there was some mention on both of your testimonies about Plus Factor in western Pennsylvania and to compensate hospitals for unreimbursed care. What seems to be the trend in the Blue Cross/Blue Shield system toward the uncompensated care financing and the graduate medical education financing? One could say it's a sin for Blue Cross having gotten us into the fix that we're in by—as I said at your meeting in Twin Cities—being the hospital protective association and the doctor protective association now to pull out of this cross-shifting system and saying, "We don't let the middle class for the poor and for education." But I can also see the practical side. What seems to be the trend in Blue Cross right now in that regard?

Ms. **Lehnard**. Senator, I will try to answer that on behalf of all of the plans. As you know, some of our plans pay costs and some pay charges for hospital services. Under both of those systems, we are picking up certain teaching costs and a substantial proportion of bad-debt and charity care. Of course, the environment is changing dramatically and very rapidly, and I think it is best characterized by saying employers are mad about their premiums. they are telling us to get the premiums down or they will self-insure. We have to respond to that.

We have two examples here of different responses. California represents a plan that has gone the competitive model and has very carefully taken into account how they are going to sustain indigent care costs in the community. I think in the Maryland example cited—and I might mention that Maryland is reconsidering its plan—they did not go to those lengths. But I think what that raises is a very fundamental question, which you alluded to earlier, and that is, what obligation do employers have to pay for uncompensated care costs? That is exactly the issue in Maryland. When Blue Cross went to hospitals where the prices were lower, there was a concern about who is going to pay for uncompensated care in the inner-city hospitals. Well, by Blue Cross of Maryland staying in those inner-city hospitals, their payment for indigent care goes directly back to employers. Employers understand this, and they are insisting—"Tell me how much my people will cost and nobody else, and that's what I want to pay or I'll find some means to do it."

It is an extremely difficult problem. It is the very thing you have raised several times today.

Senator **Durenberger**. Is that somewhat uniform across the country, or is it largely in the high-cost areas where you see most of that, like the east coast or in California? Are you feeling that pressure in the South, for example, where the average cost is lower?

Ms. **Lehnhard**. It is spreading everywhere. Obviously, in the urban areas, the high-cost urban areas where there are large employer bases, and where you have heavy industries, we are seeing it the most. But the level of sophistication now is down to employers of 200–100 now have the ability to self-insure, or go to third-party administrators. The competition is really getting all the way down to a very small groups. In some areas we haven't seen it yet, but we think hospitals are in fact beginning to position themselves as evidenced by for the drop in utilization rates, perhaps. Even though they don't see it yet in their community, they see it coming, and they are beginning to react in anticipation of it.

Senator **Durenberger**. Well, thank you all for your testimony. I appreciate it a great deal.

The final panel consists of A. Janelle Goetcheus—Dr. Goetcheus is medical director of the Columbia Road Health Services in Washington—and John R. McIntire, chairman of the Mercy Inner City Hospitals Forum, Detroit, MI.

Your statements will be made part of the record in full. You may summarize them. I take it you have been here for a while, so you have a bit of a flavor of what we consider to be some of the problems, searching for some opportunities. if you can help us in that search, we are going to be deeply grateful to you.

Dr. Goetcheus?

STATEMENT OF A. JANELLE GOETCHEUS, M.D.

Dr. **Goetcheus**. Thank you for the opportunity to share here today.

I am a physician here in Washington, and many of the patients I see are poor, many are homeless. And I want to share with you what I experience each day.

In this city, the Nation's Capital, many of the poor go without health care; in fact, many have just given up on health care. And why have they given up? There are many barriers, but I will just mention two.

One is the financial barrier. There is a myth among many people that anyone who is really poor is eligible for some type of coverage, or Medicaid. Many of the poor that I see are not eligible for any kind of coverage. That may be the woman who is 40 to 65 who formerly was on AFDC; her children have now left the home, and she is asked to go out and get a job that not only provides her rent and heat but also provides health benefits. And that's nigh unto impossible. Or it may be a gentleman who has had low-paying construction day-laborer type jobs providing no health benefits, has not gone for health care, and develops complications—complications that should never have developed. And by the time he is 50 years old he has a body of a 70-year-old. These men then, not being able to perform day-laborer jobs, end up homeless in shelters or in abandoned buildings. And even if I have someone with multiple disabilities, the only way I can get Medicaid for them is through SSI, and the qualifications for SSI have become more stringent.

The second barrier which I think is equally important, and often we don't talk about it, is the dehumanizing system itself. And I think today we have heard much in terms of the lack of financial barrier; but the dehumanizing system itself keeps the poor from going for health care.

Most of the poor in the city, in this country, must utilize the teaching hospitals, both public and private, and where there is little emphasis on continuity of care. For them it will mean long waits, it will mean being seen in multiple specialty clinics to obtain basic primary care, and it will mean being seen by multiple doctors who are in training. Each time the person goes back he sees another doctor, usually an intern or a resident, who will probably ask the same questions that they were asked before. Few of the poor ever have the possibility of having a primary care deliverer.

When I was starting practice here in Washington, one of the teenagers as she was leaving the office said, "How can you be my doctor?" And I said, "Well, just by your wanting me to be." And she said, "Do you mean I can tell people I have a private doctor?"

Few of the poor I see ever have the possibility of ever having a primary-caregiver. Instead, they are shuffled through these outpatient hospital clinics.

Faced with these barriers, the poor just simply give up and do not go. And we have all the statistics to prove this. If we look at any health statistics in terms of minorities, we see a much higher mortality/morbidity rate. Here in Washington, the cancer mortality rate among men, black men, is 60 percent higher than for white men, primarily because the diagnosis is made so late.

When will we learn that it is not only more humane but more cost effective to provide basic health care, that it is less expensive to provide care for someone with hypertension than to provide the long-term care that will be necessary when the person develops a stroke because the hypertension wasn't treated? Or when will we learn that it is much less expensive to provide prenatal care for women than having lifelong care for the handicapped child of a mother who never had prenatal care?

This is the Nation's Capital, and health care is a disgrace. Within the site of this building, people die daily, needlessly. It is like a Third World country. Washington is the Federal City, and Congress has a responsibility for some of that care. The situation is desparate, and I ask for your help.

Senator **Durenberger**. Thank you very much.

Mr. McIntire?

[Dr. Goetcheus' written testimony follows:]

TESTIMONY PRESENTED BY

A. JANELLE GOETCHEUS, M.D.

on

September 28, 1984

I am a physician in Washington, D.C. My full-time practice is in three health services which are sponsored by ecumenical churches and where many of the people who come are very poor - and many are homeless.

People who are poor are victims in many ways: they are especially persecuted by being unable to receive basic adequate health care. Many have just given up on seeking health care except when the ambulance arrives at the point of a crisis, such as when the hypertension, which has gone untreated, produces a stroke or heart attack; or when the pain of the undiagnosed cancer finally becomes so bad that they are taken to the emergency room. Poor people are victims of the health care system that creates enormous barriers to receiving care. The first barrier is the financial obstacle. Many of the poor people that I see are ineligible for any type of health coverage. There is a commonly believed myth among persons of this country - this city - that anyone who is really poor is eligible for Medicaid -- and thus eligible for good medical care. That is a myth, as many poor people are ineligible for any type of coverage.

Testimony Presented by

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SUMMARY

I am a physician in Washington, D.C. My full-time practice is in three health services which are sponsored by ecumenical churches. Many of the people who come for care are poor; many are homeless.

People who are poor are in many ways victimized by the health care system. They are often unable to obtain care-ful basic adequate care. Finding health care may be so difficult, frustrating, and demoralizing that a person who is poor may delay or fully abandon their search until their condition has become terminal. When they do resume their search for care, they often can turn only to an emergency room, where there is no coordinated care. They may see physician after physician, be referred to one specialty clinic after another, and answer the same questions each time.

It is a myth that any poor person is eligible for Medicaid or some type of government-sponsored health insurance. It is a myth that poor people have easy access to quality health care. These are myths that are propagated by many people, including physicians, and that grow out of a lack of contact with those who suffer.

To focus a health care system--its centers, its protocols, its providers--on the care of patients as people is cost effective. It is much less expensive to provide good early pre-natal care than it is to provide lifelong care for the handicapped child who is born with complications because the mother was unable to obtain pre-natal care.

In my practice I see people who cry "Why, God, why?" to the needless deaths caused by poor or no care.

This must be a question that God asks as he anguishes for his children. "Why do you in America, who claim Me as Almighty God, allow this type of care (which you would not tolerate for your own families) to exist?"

Do we not know that as a nation and as individuals we will be judged on how it is we treat our poor?

This person may be a 40-65 year old woman, a former single parent, whose children are now not in the home and therefore she is no longer eligible for AFDC and Medicaid. She is now asked to go out and obtain a job that not only pays for food, rent, heat, etc. but also provides health benefits - and that is nigh unto impossible. Or the person may be a black man of any age who is asked to find a job that provides health benefits. By the time many of the black men I see reach or survive to age 50, they have bodies of 70-year olds having worked day labor jobs, having gone with minimal if any health care, and therefore having developed complications of illnesses from hypertension, diabetes, vascular disease, heart disease, strokes - complications of illnesses that never should have developed if basic adequate health care would have been possible.

For these persons the emergency room becomes the primary source of health care, and after the immediate crisis is treated, the patient is sent home to await the next crisis. Because of their physical health problems, many of these 50-65 year old gentlemen could never maintain regular daily employment. So they end up homeless in shelters, or become squatters in abandoned buildings. And even if I have a 50-year old black man with many of these physical complications, it is very, very difficult to qualify him for SSI which is the only route he has in getting Medicaid. He must, instead, wait until age 65 before getting this health coverage, and many of the men I see will not live that long.

But as important as the lack of financial access is, equally important is the dehumanizing system of hospital out-patient clinics to which most poor people must go. In a study of the utilization of health services by people who are poor, the health care system, itself, was found to be one of the barriers of access resulting in a limited use of health services by the poor people. Among its findings were the following: "To begin with, access itself is often difficult. Physicians tend to be scarce in poverty areas, and travel difficulties are often compounded by inadequate transportation. Access problems frequently continue in the form of long waits in the providers' office or clinic. But beyond access, lies a more fundamental problem: a dual system of medical care in which the poor utilize public sources - hospital out-patient clinics, ER's and public clinics - while middle and upper income groups utilize private sources - physicians in solo and group practice."

"In the so-called "publice sources" - an ironic name in the light of their frequently high charges - organizational problems are commonplace. Patients must often maneuver between multiple clinics to obtain basic primary care services, and these services are usually disease-oriented rather than preventative. Further, the atmosphere in such institutions is often dehumanizing. To the low income patient the institution may seem "terribly massive and complex, crowded and busy," while the personnel seem often "impersonal, brusque and even insulting" - the physicians go from patient to patient spending brief moments with most. Patients may sit for long periods of time waiting to be called. Patients see all of this and they simply respond fatalixtically to the rush and bustle."

Specifically, what does health care in this type of setting mean? For one thing, it means long waits in hospital out-patient clinics. One of our nurses accompanied a patient to one of the clinics. They arrived early in the morning. At 1:00 P.M. the nurse in the clinic came out to take his blood pressure. At 4:00 P.M. she returned to say that they were sorry, but that a mistake was made - that they did not see new patients on that day of the week and he would need to make another appointment.

One of our patients who is homeless, schizophrenic and without any type of health insurance came with a large abdominal mass. We encouraged her to be seen in the out-patient clinic for surgical evaluation. However, she was frightened. Finally, after several visits to our health service, she agreed to go to the clinic. One of the staff went with her. They arrived in the clinic at noon. At 4:15 P.M. they were told that the physician, who was a resident rotating through the service, was to leave and they would have to return another day. We have never been able to get her to return again.

Besides the long waits, it means seeing a different doctor each time you go. Shortly after I began practicing in Washington, a teenager came to us and as she was leaving the room, she said, "How can you be my doctor?" When I responded, "Just by your wanting me to be," she said, "You mean I can tell people I have a private doctor?"

For many of the persons we see, that has never been possible. Nor has it been possible to have a consistent health provider - be it physician, nurse practitioner, physician assistant, or mid-wife - to coordinate their care.

In the out-patient clinic it will mean seeing different doctor who will be flipping through your chart trying to put your medical history together, and reasking the questions that you have answered each time before. Retelling your story each time, in itself, is dehumanizing. But it also may lead to misdiagnosis and mistreatment.

Doris came to us giving a history of having had surgery ten years before for cancer of the labia. Since then she had been followed regularly in one of the hospital out-patient clinics paying $25.00 each time. She could no longer afford the $25.00 so she came to us. She had seen a different doctor in training each of the prior visits to the clinic, and the last four visits she was told she had vaginitis which was causing her pain. Unsatisfied with the diagnosis, we arranged for her to be seen by a private gynecologist who biopsied the lesion and found cancer. She died a few months later.

Besides the long waits and being seen by a different doctor in training each time, it will also mean being seen in multiple specialty clinics. Judy came to us a week before she was scheduled for a hysterectomy. She was a diabetic whose diabetes was out of control, very obese, with a history of congestive heart failure, phlebitis, and hypertension requiring hospitalization in the past. Her concern was that she was not healthy enough to undergo surgery, so she came to us for advice. She'd been treated in five specialty clinics: gynecology, diabetic clinic, hypertensive clinic, orthopedic clinic, and gastroenterology clinic. The gynecology clinic had scheduled her for the hysterectomy after noting a uterine fibroid, a benign mass. But she did not believe that they were aware of her past medical history or had communicated with the other specialty clinics. We sent her to a private gynecologist who felt that because of her overall health status, surgery was not advisable. The primary communication between the specialty clinics and the doctors therein is a note written on the chart: "It is hoped that the new doctor on the service reading the chart the next time in the next clinic is aware of the prior doctor's recommendation."

A frequent occurrence - not just here in D.C. but nationwide - is the transfer of a non-insured patient from a private hospital to a public hospital. Here in D.C., the number of transfers to D.C. General has increased yearly. In the past year the number of such transfers has increased from 200 to 800.

Often the primary focus of these hospital specialty clinics is to teach and provide cases for medical students, interns, and residents. And the teaching programs in these settings are often geared to treating diseases - not patients. For a poor person to try to understand or accept what is happening is often impossible. The focus is not on how best we may care for the poor person who must use these clinics, with little attempt being made to coordinate the person's health care. Because well-known universities are involved, it is presumed by many to be the best medical care. However, in fact, it is indeed often some of the worst medical care provided because of the lack of coordinated care for the patient. You and I would not accept or tolerate being shuffled from one specialty clinic to another, seeing a different medical student, intern, or resident each time, with no one coordinating our health care. But we allow it to happen to poor people day in and day out. And the tragic part of it is that people with low incomes believe it is all right also. As I have been told by one of my patients, "When you're poor, you don't expect that you deserve any better."

And this model serves well for the medical profession and teaching institutions. This is not true just in Washington, but is a model used nationwide. I remember my own medical education: rotating through clinics, being presented with a thick chart of a low income patient who had nowhere else to go. I was to see the patient one time - for the first and last time - trying to put together his medical history by reading the chart and asking, I know, the same questions as had been asked before. I also recall how it was thought good to get a rotation in the city hospital, as you got to do so mu[illegible] more (and frequently with less supervision).

I often feel that people who are poor are, indeed, the pawns of the medical education system - a system that is often financially dependent on the fact that poor people have nowhere else to go, with physicians paid well to provide teaching of medical students and with little emphasis placed on providing continuity of care for the persons required to use these clinics.

Therefore, when confronted with no health coverage and a system that is dehumanizing with long waits, different doctors, shuffling through specialty clinics, a poor person may give up and not seek medical attention until a crisis develops, such as when the hypertension produces a stroke, or the pain of the undiagnosed cancer reaches a terminal stage. And we have all the health statistics to reflect this kind of care among the low/no income of this city; such as the infant mortality rate and the increased cancer mortality rate among black men as compared to white men primarily because the diagnosis is made so late.

Do we not know that this kind of crisis health care is much more expensive? For it is much less expensive to provide medication for hypertension than it is to care for a person who requires long-term hospital and then nursing home care for a disabling stroke that occurred because the hypertension was untreated. It is much less expensive to provide good prenatal care than it is to provide life-long care for the handicapped child who is born premature and with complications because the mother was unable to obtain good pre-natal care. It is more effective to provide coordinated primary care through community-based health services than through out-patient teaching hospital clinics.

A frustration for me has been the difficulty in convincing anyone that there is a real problem in access to quality health care for poor people. Some of the most resistance to believing this have been my colleagues, other physicians. A medical student attending one of the medical schools here in Washington told me of hearing one of his professors tell the medical students that he did not believe that there were any unmet health needs in this city. That is a myth which is believed and propagated by many persons, including physicians, and grows out of lack of contact with those who suffer from a lack of quality health care.

In addition, Washington is not considered a medically under-served area by the National Health Service. Because we have three medical schools here in the District and many physicians, it appears, statistically, that this citty's poor people would have more than enough physicians to care for their needs. The District has tried in vain to obtain National Health Service physicians, most recently trying to obtain a bilingual OB/GYN physician for the estimated 60,000-80,000 Central American refugees who have come to Washington.

Persons who are homeless are victims in additional ways. Daily, on the streets of Washington, homeless men, women, and children who are ill walk the streets because they are only allowed to stay in the shelters at night. Daily, after seeing a homeless person who is ill, but not sick enough to require hospitalization, I send him out to walk the streets again often in freezing or very hot weather. What was a minor illness, such as a respiratory infection, becomes pneumonia; what was a small ulceration becomes a large ulceration eventually requiring amputation.

I wish two of my patients, who were homeless, were here to tell their own stories. They are dead. Mr. Willis is a 62-year old, very thin looking gentleman who had been homeless for about two years. During the past very cold winter, he was taken to a private hospital emergency room, treated for hypothermia and released to the shelter. The shelter staff noted how weak he apperared. They called the emergency room physician who said that Mr. Willis just needed some food and to be kept warm. He was seen the following day in one of the health services and admitted to a hospital. He had a hemoglobin of 6 which is less than half of normal, and died shortly thereafter of terminal cancer.

Another one of our patients was a 74-year old gentleman who froze to death on the streets of Washington a year ago. I will never forget the first time he came to the health service. When I walked into the exam room, he was sitting on a chair humped over with his wet coat pulled up over his head trying to get warm. He had no shirt under the wet coat, only bare cold skin. His trousers were soaked and he had no socks. He stayed with us that day and was given dry clothes, and then left to go back to the shelter. He was to return to us to continue application for better housing placement. However, he froze to death before this occurred.

Recently I was at a wake of a baby who was a victim of all that poverty brings - death. A relative, who had helped care for the child, lay on the floor at the foot of the casket and wept and wept and wept - her whole body and soul in agony. This was the woman who had told me a few weeks before that her boss was a white man who was prejudiced. "He shakes his finger in my face and says, 'When I talk to you, look at me." But I don't say anything. I want my job."

And as I knelt beside her on the floor in front of the casket of the child, she cried out in anguish, "Why, God, why?"

I think this must be a question that God asks as he anguishes for his children: "Why do you in America, who claim me as Almighty God, allow this type of health care to exist?"

Do we not know that as a nation and as individuals we will be judged on how it is that we treat our poor?

STATEMENT OF JOHN R. McINTIRE, CHAIRMAN OF THE MERCY INNER CITY HOSPITALS FORUM, DETROIT, MI

Mr. McIntire. Thank you very much, Senator.

I would like to thank you for the opportunity of testifying and for holding these hearings, to allow an expression of these kinds of problems.

My name is John McIntire. I am president of Samaritan Health Center, which is a health center in the city of Detroit composed of two hospitals and a primary care network, and I am also chairman of a group called the Mercy Inner City Hospital Forum. Since it is explained in my paper, I won't get into a description of precisely what the forum is, but let me just say it is composed of hospitals who, for one reason or another, basically because of a commitment to serve, have chosen to stay in the inner cities where the populations that they have treated have always been there, and stay and try to, despite adverse conditions, continue to provide care to those populations.

Let me just say that the dominance of the marketplace orientation is aggravating everything that we are talking about here today. I really do feel, being the last speaker, much has been said already, and I will try not to duplicate so much of the previous comments.

I think what I would like to do, in the main, is support a lot of the problems that have been reported both in my own text and in previous testimony and to maybe just make some comments.

One is that there has to be some relief to these hospitals who provide care to a disproportionate share of the poor. Congress has recognized this, the Health Care Financing Administration has not acted on this, and I believe Congress has spoken again. Nothing has been forthcoming yet. We really look toward some help that has already been recognized as being needed.

The other kinds of issues have been reported in research papers, which I am sure your staff have made available to you. It is that the problem that we are talking about in health care delivery to the poor, especially in the inner city, falls very, very unevenly. And it falls unevenly because of the geographical pockets of poverty. So it doesn't fall on all hospitals the same way, and therefore, problems suffered by the inner city hospitals that are providing this care are not exactly the same kinds of problems that are suffered by all hospitals. Indeed, there is a great difference.

As has been said before, the problem is a societal one. It is not answered by institutions. Institutions are providers of care, they are not financiers of care.

A couple of comments from earlier testimony that, if I could, I would like to make. One was the relationship of lack of employment, and then uninsurability, and then Medicaid eligibility. I would like to follow up.

Some research has been done recently at the University of Michigan Institute for Social Research. Basically, it is that most people who lose their jobs lose their health care insurance. Now, that may seem perfectly obvious to some, but it has been challenged in the past. And most of that loss occurs within the first 4 months, despite the fact that there are spouses, a private family. Still and all, a majority of those people who have lost their employment have indeed lost their health insurance.

The interesting followup feature as part of that study is that three-quarters of those people, then, who have lost their insurance that have been studied in southeastern Michigan, 75 percent of those people are not eligible for Medicaid. That is part of the problem that we are talking about.

Moving quickly to another comment on the community health centers, we are a recipient of the Community Health Center Grant funding. I don't really know that closing community health centers is a sign of success; but currently we operate a network of primary-care centers within the city of Detroit, trying to provide this care. And our funding has been reduced both at the State level and at the Federal level on the Community Health Center grants. So we are now losing $2 million a year in that network. We have lost cost-based reimbursement and Medicaid through the Michigan cutbacks, and I can tell you—well, starting with a basis of 30 percent of funding, Federal funding, for the primary care network, it is now down to 12 percent. We are talking about a network in which there is an annual increase of patient care. We are now providing 78,000 visits a year, and the Federal Community Health Center funding has now been reduced, if you will, to 12 percent of our total budget.

Basically, commenting about the primary care physicians in the inner city, I think it is very laudatory to get to the geographical distribution problem of health care, physicians especially, and health care availability. I have a great respect for the American health care system to follow the American dollar. And I think if there are dollars available in there, I think there are physicians, if you will, who are even willing to give service in those areas, even though they are not very attractive areas. But it is related also not just to the training of physicians but to the lack of funding for those patients.

I will just conclude, having said what so many speakers have said and what you, Senator, also have said: It is a societal problem.

I will give you a final example of just two of our hospitals in the city of Detroit. The city of Detroit has no public general hospitals. It used to have two available—to Wayne County residents, but there are none now.

I think it would be very interesting if some researchers would tell us how many communities in American do not have an public general hospitals.

Two of ~~our~~ hospitals in the inner city have provided $12.2 million of uncompensated care last year. And we just cannot continue to do that, because we just don't have the funding available.

Thank you very much for the opportunity to make this presentation, Senator.

Senator **Durenberger**. I appreciate your statement.

[Mr. McIntire's written testimony follows:]

TESTIMONY OF THE
MERCY INNER CITY HOSPITALS FORUM

John R. McIntire, Chairman

Mr. Chairman and Members of the Subcommittee:

The Mercy Inner City Hospitals Forum ("Forum") appreciates this opportunity to present its views on the critical issue of health care for the economically disadvantaged. We commend the Subcommittee for providing this opportunity for much-needed public discussion on the societal goal of ensuring access to quality health care services.

The Forum is a consortium of ten Catholic-sponsored hospitals located in, and serving residents of the following nine inner city areas: Baltimore, Detroit, Chicago, Philadelphia, Toledo, Pittsburgh, Denver, Cleveland, and New York. Representing over 5,200 beds, its membership in the Forum includes the following:

Mercy Hospital, Baltimore, Maryland
Samaritan Health Center, Detroit, Michigan
Mercy Hospital and Medical Center, Chicago, Illinois
Mercy Catholic Medical Center, Philadelphia, Pennsylvania
Mercy Hospital, Toledo, Ohio
Mount Carmel Mercy Hospital, Detroit, Michigan
Mercy Hospital, Pittsburgh, Pennsylvania
Mercy Medical Center, Denver, Colorado
St. Vincent Charity Hospital, Cleveland, Ohio
St. Vincent's Hospital and Medical Center - New York, New York

For these institutions, a commitment to the poor and underserved has been demonstrated by decisions not only to remain in inner city areas but also to expand and develop new services.

The Forum was organized in 1978 to provide a vehicle for the leadership of inner city hospitals sponsored by the Sisters of Mercy to examine common concerns. The mission of the Forum is to strengthen the role of its member hospitals in providing service to the inner city poor. Consistent with this vital mission, and in recognition of a need to create a stronger voice in the public policy arena, the Forum recently expanded its membership to include other Catholic inner city hospitals. In addition, the Forum has established on-going communications with several other non-profit community hospitals located in urban areas throughout the United States.

TESTIMONY OF THE
MERCY INNER CITY HOSPITALS FORUM
SEPTEMBER 28, 1984

Highest among the concerns of hospitals represented by the Forum is the issue of financing health care for the poor. As a representative of the Forum I will speak to this issue. As Chief Executive Officer of Samaritan Health Center in Detroit, Michigan, I will provide you with a few examples as to how health care for the poor is being financed by one of the nation's inner city hospitals.

If health care delivery today faces challenges hitherto unknown to the industry, inner city health care facilities face not only these challenges but also threats to their very survival. With large numbers of persons who are unemployed, uninsured, and unable to pay for health care, with states running out of money -- a fact which more adversely affects inner city areas than suburbs -- with Hill-Burton facilities aging, with no allowable return on equity for not-for-profits, inner city health care facilities are buffeted from all sides. Moreover, changes in the environment, particularly the economic environment, threaten the very ability of the inner city hospital to carry out its mission.

It is generally believed that all hospitals try to make the health care system work, regardless of the system's enormous problems and gross inequities. I would contend, however, that this statement is most true of inner city hospitals. Hospitals that choose to remain in our nation's inner cities do so as part of a commitment to serve the patients in their own communities, regardless of the fact that their patient populations overwhelmingly suffer severe health problems, and are uninsured or lack financial resources to pay for needed health care services. Inner city hospitals try to make the system work; they do their best to try to reach the goal of ensuring access to quality health care services. The efforts of these providers in caring for the poor, while admirable, are also by their very nature inadequate, non-systematic, and financially destructive to their institutions.

The problems of providing health care to the indigent are compounded by the unevenness in the geographical-distribution of poverty. The problems then do not affect all hospital providers in the same way. Far from it -- the poor, especially in urban areas are concentrated in geographic pockets, and the institutions which serve these populations are being jeopardized to a point where their survival is threatened. It is important to note that this situation is not unique to one type of hospital. It exists, in varying degrees for most non-profit community hospitals, non-teaching hospitals, teaching hospitals, university hospitals, and public general hospitals that are located in impoverished areas, and which largely serve poor populations. The basis and extent to which health care for the poor is financed by these institutions varies, in some cases, to a considerable degree.

Within our society there are many communities that have neither public general hospitals nor university hospitals. In these communities care of the indigent is entirely cast upon and assumed by private non-profit hospitals with no special provisions for financing the care of the non-certified indigent. For example, in Detroit five years ago there existed two public general hospitals available for the medically indigent. Today, there are no public general hopsitals to provide services to the indigent in the City of Detroit.

Samaritan Health Center, Detroit, is a Division of the Sisters of Mercy Health Corporation headquartered in Farmington Hills, Michigan, and is a member of the Forum. Samaritan Health Center is comprised of three organizational components: St. Joseph Mercy Hospital, Evangelical Deaconess Hospital and the Primary Care Initiative Program which will be described in detail subsequently. All of the organizational components of Samaritan Health Center are located within the inner city of Detroit, and basically, in areas with large indigent populations. The patient payor mix at Samaritan Health Center reflects this fact: Medicare, 42%; Medicaid, 29%; Blue Cross and Commercial Insurance, 19%; Self Pay, 6%; and HMO (primarily Medicaid recipients), 4%. Since Fiscal Year 1982, uncompensated care (charity care and bad debts) provided by the institution has increased dramatically as a percentage of gross patient revenues. Between 1982 and 1984, the institution provided uncompensated care totalling $10,406,200. Over $3 million in uncompensated care is included in Samaritan's 1985 operating budget.

TESTIMONY OF THE
MERCY INNER CITY HOSPITALS FORUM
SEPTEMBER 28, 1984

The phenomenon of "cost shifting" has been reported elsewhere as a great problem, and as an inequitable tax on private payment mechanisms. In the past it has, however, served as the primary means of financing uncompensated care for a number of hospitals. It is evident that, for an institution with a payor mix like Samaritan Health Center, cost shifting does not offer even a temporary solution to the problem. Providers which predominately serve patients covered by publicly financed programs, like Medicare and Medicaid, and large numbers of uninsured patients have no revenue base upon which to shift costs. All of this leads to the issue of how health care for the economically disadvantaged is currently being financed under such circumstances -- one of the primary purposes of today's hearing. As cost shifting becomes less and less of an option, and as fewer public institutions remain open, hospitals that do accept and treat indigent patients, in essence, will be financing that care out of an erosion of their own financial equity.

For example, in 1981, Samaritan Health Center reported equity in excess of $13 million at its year-end audit. At the present time, due to the problems mentioned previously, and aggravated by federal and state cutbacks in reimbursement/payment for health care services, Samaritan Health Center is now in a position of negative financial equity. This is a situation which cannot continue if Samaritan is to viably fulfill its mission of service to both poor and non-poor individuals residing in its service area.

As was touched upon previously, there is a very strong interest, among many hospitals throughout the country, to sustain the long-standing public service commitment of the non-profit community hospital -- demonstrated by a willingness to provide access for all patients that require care. The current health care environment, characterized by a lack of financing for the non-certified poor, reduced federal and state support for health care services, and also an increased movement toward a market-selection orientation in health care, is severely threatening this public service commitment. Patients who are uninsured or underinsured simply do not represent an "attractive market" for hospitals interested in maintaining their financial viability. For hospitals that continue to maintain their public service commitment, the future looks bleak; survival in the short term appears to be even more questionable. The real tragedy is that those institutions that have historically exhibited the greatest social concern are also those that the nation's health care system, and more importantly, the nation's poor, stand to lose.

I would like to provide one final example of Samaritan Health Center's experience in providing health care to the economically disadvantaged in Detroit. In 1978, in an effort the meet the known problems of access to health care services for the indigent in the inner city, a new public-private primary health care program was initiated between the Sisters of Mercy Health Corporation, Samaritan Health Center, Mount Carmel Mercy Hospital, The Robert Wood Johnson Foundation, and the Department of Health and Human Services. This collaborative effort resulted in the development of what has been named the Primary Care Initiative Program (PCI). The PCI Program consists of a network of four primary health centers located in federally designated medically underserved areas in Detroit. While the Program has been designed to be attractive to all persons in the communities served, it was also designed to serve, foremost, persons who would generally be denied access to health care due to their inability to pay. The record of the Primary Care Initiative, its patient care and financial history, provides an interesting vignette in the history of public-private initiatives in the delivery and financing of health care for the poor.

Since 1980, the PCI Program's first full year of operation, patient encounters have increased from approximately 20,800 to over 78,000 annually. With this increase in patient activity, the cost of the program has also increased. At the same time, federal operating support for the program (Section 330, Community Health Center funding) has remained at the same level since 1982, thereby representing a decreasing proportion of funding necessary to support the Program. In addition, recent policy changes in the state's Medicaid Program have resulted in severe reimbursement shortfalls for the Program. These factors, along with an increase in unsponsored indigent patients entering the PCI Program, have resulted in Samaritan Health Center contributing approximately $2 million annually in support of the Program.

The Mercy Inner City Hospitals Forum believes that it is important that the Congress recognize that the situations just described cannot and need not continue. If hospitals which serve a disproportionate share of the nation's poor are to continue to provide a vital community service, their special needs or financial requirements must be taken into account. Indeed Congress, in adopting P.L. 97-248 (The Tax Equity and Fiscal Responsibility Act of 1982), and P.L. 98-21, (the legislation that initiated the Medicare prospective pricing system) included a provision granting the Secretary of Health and Human Services the authority to give special consideration to hospitals which serve a disproportionate number of patients who have low incomes or who are entitled to benefits under Part A of Medicare. This provision has never been implemented, despite congressional concern that hospitals that serve heavy Medicaid, Medicare, and/or indigent patient populations may not be receiving adequate federal payment.

The Mercy Inner City Hospitals Forum has, since July of 1983, provided written comments to the Health Care Financing Administration expressing its concern about the adequacy of efforts that have been made to date in implementing the provisions contained in both the 1982 TEFRA legislation and 1983 prospective payment legislation. The Mercy Inner City Hospitals Forum believes that the Secretary's failure to implement this provision must be addressed as a means of providing some financial relief to those hospitals which are experiencing financial distress as a result of providing services to a growing number of economically disadvantaged patients.

The Mercy Inner City Hospitals Forum believes strongly that the issue of financing health care services for the economically disadvantaged is not one that can be adequately or equitably addressed at the institutional level. Rather, it is an issue of such critical importance that it warrants further public discussion and a public policy response.

Senator **Durenberger**. I am going to ask both of you sort of an idealistic question, because it is a little unreal, and yet the answer to it is important from my standpoint as we try to sort our way out of both the responsibility issues and the financing issues.

Dr. Goetchues does make a point that has not been made that I can recall so far in our hearing. She is describing the typical system that you will find in what we have come to call the inner city.

She says:

> Well known universities are involved, and it is presumed by many to be the best medical care. However, the fact is, it is indeed often the worst medical care provided because of the lack of coordinated care for the patient. You and I would not accept or tolerate being shuffled from one specialty clinic to another, seeing a different medical student—intern or resident—each time, with no coordinating of our health care, but we allow it to happen to poor people in this country year in and year out."

Now, the question I have to keep asking myself and that I have asked the previous panel, in effect, is: If we were to start all over again after the Second World War to take care of the veterans' health needs in this country, would we have created a whole bunch of veterans' hospitals, or would we have done what we did—smartly, I think—with the G.I. bill, and entitled everybody to buy a university education? We have seen what that did to our education in this country.

Now we are faced with a situation where we have Government hospitals and we have private hospitals, and they are there, and they are very expensive and they all have to pay off their debt.

What I hear is that somehow those hospitals have to survive because they are the means, the only means, that many of the poor have, even though it is inadequate, to get any health care at all.

But I have watched some experiments in the Twin Cities and have gone into some of the HMO's and talked to people where they are experimenting with, in effect, financing the poor. They walk into a prepaid health care facility like an HMO, and they may not be dressed the same, but their card is an HMO card. You can't tell whether they are totally unsupported financially or whether they are Medicaid, or what they are. There is their card. Or whether they are the richest people in town.

So, yes, they may not see the same doctor each time, but at least it is in the same setting. The charts are always there. It is likely that if you want to wait a little bit you probably will see the same doctor. Personnel do not turn over that much in that kind of a setting.

It keeps striking me that, if it is good for the middle- and upper-income folks in this country to utilize systems like that, I can't understand why that is not a preferable way for us to go with regard to those who are financially disadvantaged.

Would you react in terms of if you could start the system from scratch today? Would it be preferable to start it with consumer financing as opposed to building the institutions and then inviting the consumers to come in, and then sending the bill to some payor, depending on what their economic status was?

Mr. **McIntire**. Well, that's a very good series of questions. I will try to respond.

I think one of the things that you are raising is that there can be a better organization of health care than currently is being provided, and I would agree with that. I am not sure how to rebuild the entire health care system, but to the extent that there is a more effective or more productive method of delivery, I think we are required to get into it, not just a good thing.

In the instance which I am describing here, we have applied, if you will, for permission with the State to provide a capitated ambulatory program and to start building off this primary care center into something like that. As a matter of fact, it is very interesting. Lacking a capitated program that we have right now, the primary-care initiative has made serious reductions in inpatient utilization, simply because the doctors in that program have different motivations.

So to the extent that it can be organized more effectively, we simply must be mandated to do that.

I will just make one other point on that, and that is, for the community that I represent, having gone through the recent recession, especially with the city of Detroit and the automotive industry, one of the problems that was mentioned earlier is that it is not just the question of using the Medicaid funds more efficiently; one of the big problems is that there aren't any funds for a certain segment of the population. Now, if we could get some funds for that segment, I think these delivery mechanisms would certainly be a cost-effective way of doing it.

The problem is, the unemployment, uninsurability, and ineligibility for any kind of funding is one of the real things that we haven't been able to solve. And nobody else has really been able to cope with it. But there has got to be a better way of delivering that care, and I think there are some models out there. It is the coverage that is the most important factor.

Senator **Durenberger**. Thank you.

Dr. Goetcheus?

Dr. **Goetcheus**. Well, I would say your model is a very, very good one. The most resistance we had when we raised that kind of a model was among physicians and among the teaching facilities themselves, because physicians are paid very well to go into these teaching hospitals. And they have their own private practices, many of them, and they are paid to go into the public hospital maybe 4 hours a week, and they are paid very well to do this.

When you begin talking about setting up an HMO so that those patients aren't funneled through that hospital outpatient clinic, that's stepping on their livelihood. And the emphasis is not on how best we can treat these people; it's on how we can teach the medical students coming through that public hospital.

Senator **Durenberger**. In Detroit is there—I'm not quite sure, John, what the forum is that you chair, but is it in part a process?

Mr. **McIntire**. No. The forum really is built from the Sisters of Mercy Hospitals throughout the country that have chosen to remain in the inner city as part of their commitment. So it represents 10 hospitals. We have since added a couple of Catholic but not Sisters of Mercy hospitals. So we are in Baltimore, Detroit, Chicago, New York, Cleveland, and places like that.

And the forum basically gets together on its own to deal with these kinds of issues, because the high focus that we have is in inner city hospitals and especially in health care for the indigent. That is our focus, and that is really why the forum is organized.

Senator **Durenberger**. But you are from Detroit?

Mr. **McIntire**. Yes, Senator.

Senator **Durenberger**. In Detroit is there any kind of a formal or informal planning process regarding the hospital problem itself in terms of if I wanted to go into the hospital business in Detroit how would I go about doing it? Could I come in, or does that State have a process there that would keep me out?

Mr. **McIntire**. Do you mean as far as new hospitals?

Senator **Durenberger**. Yes.

Mr. **McIntire**. Yes. As far as new hospitals, first of all there won't be any new hospitals being built in our service area. The only brand new hospital that has been approved in the southeastern Michigan area has been a proprietary hospital that has been built in the area of West Oakland County, which really serves Bloomfield Hills and a very well-to-do area.

It is a very interesting comment on the certificate of need process. Both the Health Systems Agency and the Department of Public Health refused the certificate of need for that hospital; both turned it down. They were both sued, and the proprietary institution won the suit. There is now a certificate of need for a 100-bed hospital in the suburbs that nobody really feels is necessary for health care.

I don't know if I have answered your question about how to get into health care.

Senator **Durenberger**. Well, it sounds to me as though the State has a process to make sure I don't get in, if I want to.

Mr. **McIntire**. Yes, there is a certificate of need. That's right.

Senator **Durenberger**. It has sort of given you your hospital franchise, and everybody else who is there has a franchise to operate. And if I wanted to come in and say I could do it for $100 a day less, or something, they wouldn't let me in the door. Is that right?

Mr. **McIntire**. Well, as a matter of fact, the market to be served by the hospital in question is really not a Detroit market. And there has been some discussion here about transportation. By and large, generally speaking, people have not gone from the suburbs into the inner city to seek health care. It is just not a phenomenon that has occurred in the city of Detroit.

There is no question about it, there is overbedding. But I think that, more than anything else, is the reason for the HSA's refusal to grant that certificate of need.

Senator **Durenberger**. Do you know how many people in Detroit or in the Detroit area belong to alternative health plans like HMO's or EPO's?

Mr. **McIntire**. I really can't give you an exact number. In the testimony I provided there is a fair amount of Medicaid HMO activity, and our hospital has almost 5 percent of its patient load in HMO activity.

Senator **Durenberger**. Is that growing in Detroit?

Mr. **McIntire**. I would say HMO's are growing generally, so it is probably growing. It is not growing very fast. I believe what is the largest HMO in the State has been backed by the "Big-Three" automakers and the UAW. That is growing and a couple of years ago had 80,000 subscribers. I am sure it is over 100,000 now. That is growing.

Senator DURENBERGER. Do the United Auto Workers control an HMO, so that they would be unlikely to encourage their members to buy from other HMO's? Is that the way it works in Detroit? I don't want to get too far off the subject, though.

Mr. McINTIRE. Would they discourage going into another HMO?

Senator DURENBERGER. Do they own one of the HMO's? The one that has 80-100,000?

Mr. McINTIRE. No, they don't own it. They are represented on the board, along with the "Big-Three" automakers. Of course, as you probably know, with the negotiations there is a very big and important activity that goes in in the negotiations that includes health care benefits. By and large the UAW would resist any erosion of health care benefits; but there still is the availability to pick Blue Cross coverage as well as to pick that HMO for UAW workers. I am not an expert on UAW coverage, but there is that choice still.

Senator DURENBERGER. Thank you both very much. You have added a great deal to our understanding of the problem and maybe some of the opportunities to resolve it.

Mr. McINTIRE. We much appreciate that.

Senator DURENBERGER. Thank you.

The hearing is concluded.

[Whereupon, at 12:12 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made part of the hearing record:]

Testimony of the Children's Defense Fund Before the Senate Finance Committee Subcommittee on Health: Health Care for the Economically Disadvantaged

Presented by
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Children's Defense Fund
122 C Street
Washington, DC 20001
(202) 628-8787

October 1, 1984

Mr. Chairman and members of the Subcommittee:

The Children's Defense Fund appreciates the opportunity to submit testimony before the Subcommittee on the issue of health care for the economically disadvantaged. Because of the sheer extent of poverty and uninsuredness among American children, no issue in federal health policy is more important than how the problem of medical disadvantage is addressed. Indeed, the remedial approaches to health care for the medically indigent will ultimately determine the appropriateness and accessibility of the health care system for children and pregnant women. Ultimately, if we fail to adequately address children's needs in fashioning approaches to uncompensated care, the nation will pay in longterm costs, both human and fiscal, that might have been avoided through the provision of appropriate services to pregnant women, infants and children.

In order to appreciate poor children's stake in the medical indigency debate, and to fashion suitable remedies, we must answer the following preliminary questions:

- What is the extent of the medical indigency problem among children, and who are the children most in need of assistance?
- What is the health status among poor children, and is their current utilization of services commensurate with their need?
- How are medically indigent pregnant women and children currently meeting their health care needs?
- Do wide gaps in appropriate health care coverage for pregnant women and children make sense?

1. WHAT IS THE EXTENT OF THE UNCOMPENSATED CARE PROBLEM AMONG CHILDREN, AND WHO ARE THE CHILDREN MOST IN NEED OF ASSISTANCE?

We are in the midst of a veritable epidemic of poverty among children. One in four children under age six lives in poverty. (1) Between 1979 and 1982, childhood poverty grew by one-third -- the greatest rate of increase since poverty statistics were first collected. (2)

The association between poverty and health insurance status is borne out strikingly among children. Several studies have attempted to estimate the extent of uninsuredness among children. In 1978, prior to the most recent recession and the rapid growth in childhood poverty, the Congressional Budget office, using data from the Survey of Income and Education (SIE) estimated that 14% of children under age six and 11.2% of children ages 6-18 were uninsured. (3) Moreover, CBO found that children were a somewhat disproportionate percentage of the uninsured population, comprising 33% of the general population but close to 40% of the uncovered population. (4)

In 1982, using data from the 1977 National Medical Care Expenditure Survey (NMCES), Wilensky and Berk determined that, among poor and near-poor children (those with family incomes of $10,000 per year or less for a family of four) approximately two-thirds were either never insured or else were publicly or privately insured for only part of a year. (5) Only 34% of poor and near-poor children were either always insured under Medicaid or else insured all year through a combination of Medicaid and private insurance. (6)

On the basis of a 1982 survey on access to health care, the Robert Wood Johnson Foundation estimated that, in that year, 7 million children lacked health insurance. (7) Most recently, the Urban Institute estimated that the number of uninsured grew from 28.7 million Americans in 1979 to 38.6 million by 1982, with children representing forty percent of the uninsured (15 million) or one out of every five American children. The Urban Institute also found that, whereas in 1979, 25% of the uninsured had family incomes below the federal poverty level, by 1982, the percentage of the uninsured living below the poverty level had grown to 32%. (9)

Thus, from these studies a disturbing picture of uninsured children begins to emerge. First, in general, the extent of uninsuredness among children appears to be on the rise. In 1978, CBO estimated that 12-15% of children were uninsured; by 1982, according to the Urban Institute, that number had increased to 20%.

Second, uninsured children appear to be disproportionately and increasingly concentrated in poor families. Since 1978, children, especially young children, have been increasingly concentrated in poor families -- families in which, according to the 1977 NMCES data, only one in three poor children are insured throughout a year.

There is no reason to believe that these trends have reversed themselves significantly since 1982. Indeed, we suspect that they may have worsened. First, the recession led to the loss of health insurance among significant numbers of families. Second, between 1978 and 1982, because of increasing childhood poverty rates and flat eligibility rates, the percentage of poor children receiving Medicaid benefits declined significantly. (11) In Fiscal 1983, the number of child Medicaid recipients did not merely again decline in relation to the growth in childhood poverty rates: the number dropped in absolute terms, as well, from 11,110,328 to 10,743,633. (12) Between 1982 and 1983, 200,000 more children fell into poverty (13), but 366,695 fewer were served by Medicaid.

Thus, among the more than 13 million children living in poverty today, we might expect more than 8 million to be either completely uninsured or else insured for only part of the year. By definition, these children are living in families who do not have the disposable cash to substitute for health insurance.

Determining who these children are is as important as trying to determine how many there are. There is no single description of the type of family in which an uninsured poor child lives. Many of these children can be found in unemployed families or families not connected to the workplace; others are members of families in which the household head (or a household member) is employed:

- A 1977 study of families with minor children receiving Social Security Survivor's benefits (14) determined that, among 605,000 families nationwide headed by widows, 31% were without any health insurance at the time of their husband's death. Only 18% had insurance through the wife's place of employment. Within 6 months of the husband's death, 45% of the insured had lost their coverage, primarily because the deceased husband's employment-based coverage lapsed. By the time the survey was actually conducted, 26% of all the families, and 34% of the 79,000 families with children under age six, had no health insurance. Younger families were also more likely to be poorer, because the widow was not able to reenter the work force due to the presence of very young children.

- A sizeable portion of poor children live in unemployed households. By 1982 it was estimated that over 16 million persons, half of them dependants, had lost health insurance coverage because of unemployment. (14a) Between March 1979 and March 1983, 1 million American children had all parents unemployed. (14b) Children living in unemployed two-parent households increased by 250% during these years -- the biggest percentage increase among all types of unemployed households. Over half of these 1 million children lived in female-headed households, which were significantly poorer to begin with. (15)

- Among low income children and dependents living in an employed household, uninsuredness is also pervasive. CBC determined that among uncovered children, half lived with a covered family head. (16)

- Even among children who live in households in which some form of health insurance apparently exists, there are striking problems of underinsuredness. Children eligible for Medicaid may live in states in which severe limitations are imposed on coverage of such basic services as hospital and physician's services. For example, a number of states now limit coverage for hospital care to as few as 12 days per year. In these states, accessibility of crucial services, especially for chronically ill children or high risk infants, is severly compromised.

Furthermore, even where children live in poor families with private insurance, the insurance may be totally inappropriate to children's needs. In 1978 CBO found that only 9% of private insurance plans covered preventive care; 32%, children's dental care, and 14%, children's eyeglasses. (17)

2. WHAT IS THE HEALTH STATUS OF POOR CHILDREN, AND IS THEIR UTILIZATION OF SEVICES COMMENSURATE WITH THEIR NEED?

Why should we be so concerned about widespread underinsuredness among poor children? Because the evidence shows that: a) poor children suffer a significantly lower health status than that of their non-poor counterparts; b) poor children underuse health care in relation to their increased need; and c) health insurance coverage is directly tied to utilization of health services.

a. The Health Status of Poor Children

Among children, poverty is strongly associated with reduced health status. (18) Poor children have 30% more restricted days of activity and lose 40% more school days because of illness. (19) Three to six times as many poor children are likely to be reported in fair to poor health, and poor children are 40-50% more likely than non-poor children to be found to have a significantly abnormality on physical examination by a physician. (20)

Mortality among poor children is significantly related to poverty. Neonatal mortality is 150% higher (21) and postneonatal mortality rates are 200% higher. (22) And, because non-white children are disproportionately poor, these disparities in health status are directly reflected in black infant mortality rates, which are nearly twice as high as white infant death rates.

Mortality statistics among poor children continue to remain high after the first year of life. Poor children are one and one half to three times more likely to die in childhood. (23) Moreover, perinatal problems that do occur have a greater impact and more sequalae in poor children. (24) Thus, poor children who survive infancy are at greater risk for a lifetime of handicaps and reduced productivity.

There are indications that over the past several years the health risks facing poor children have heightened:

- Babies born to mothers receiving little or no prenatal care are three times more likely to be low birthweight, and low birthweight increases the risk of death 20 times. (25) Yet after nearly a ten-year period in wich an increasing number of women began prenatal care early in pregnancy, since 1980 there has occurred a nationwide erosion in the percentage of women receiving early prenatal care and an increase in the percentage of women receiving little or no prenatal care. (26)

  The trend has been particularly severe among non-white women, whose babies were already at heightened health risk. In a national survey of natality statistics, eighteen out of 23 states reporting natality data by race showed an increase in the percentage of non-white women receiving little or no prenatal care. Nineteen of 23 states reported a decrease in the percentage of non-white women receiving prenatal care early in pregnancy. (27)

- Between 1978 and 1982, there ocurred a serious decline in the percentage of preschool children adequately immunized against disease. In 1978, 51.7% of Black preschool children were not fully immunized against diptheria, pertussis and tetanus. By 1982 that figure had climbed 50 66%. (28) In 1978 60.7% of Black preschool children were not adequately immunized against pneumonia. By 1982 the number had climbed to 65%. (29)

b. Children's Utilization of Health Services in Relation to Their Need

A number of studies show that, when adjusted for health status, children and pregnant women seriously underuse health services:

- Among widows and minor children receiving Social Security Survivor's benefits, 2.6 times more reported a minor child in fair to poor health than among the general population; and 3 times more widows, aged 17-44 reported fair to poor health than women in the general population. Yet children in these families had a third fewer physician visits (3.0 per year) than children in the general population (4.1 per year). Widows similarly had fewer physician's visits. (30)

- The Robert Wood Johnson Foundation, in its 1982 study, found that while the poor who actually obtained health services used more than the non-poor (5.9 physician visits vs 4.7 physician visits per year) the poor were twice as likely as the non-poor to be unable to obtain any service. (31)

- A study of uninsured poor in Arizona prior to the advent of that state's Medicaid demonstration project (32) found that, while low income persons were significantly more likely to report themselves in fair to poor health than the poor population nationwide (32% vs 26%), over 15% of the Arizona poor, as compared to 11.9% of the poor nationwide, did not have a usual source of health care. Arizona's poor reported an average of 4.6 physician visits per year, as compared to 5.9 per year for the poor nationally.

  While 8.9% of the U.S. poor reported being unable to obtain health care, among Arizona poor 10.7% of families were unable to obtain needed care. Over 5 percent said they were refused health care, compared to 2.8% of the poor nationwide.

- Researchers at the National Center for Health Statistics, reviewing 1978 Health Interview Survey data, found that, adjusting for health status, the poor received substantially fewer services than the non-poor (3.5 - 4 visits/year vs 5.2 visits per year). (33) Disparities in the use of preventive services were particularly striking; low income women were less likely to receive prenatal care, pap smears and breast exams, and young low income children were less likely to be immunized. (34)

c. The Effects of Health Insurance Coverage on Health Care Utilization

When individuals' utilization of health services is considered in light of the effects of health insurance, it is evident that the uninsured use substantially fewer services than their insured counterparts:

- 1978 HIS data showed that the uninsured poor received one-third fewer physician visits than those with Medicaid and 16% fewer visits than other insured persons. (35)

- 1977 NMCES data revealed that the uninsured were least likely to receive hospital, physician and drug services. A 300% difference in hospital usage existed between the uninsured and the insured. When the uninsured sick were compared to the insured sick, the uninsured used 50% fewer physician services and 25% as much ambulatory non-physician services. (36)

- In its 1982 study, the Robert Wood Johnson Foundation found that one million families were refused care because they were unable to pay. (37)

Thus, given poor children's lowered health status and their general underutilization of services relative to need, we should be particularly concerned about the situation of uninsured poor children who are without resources to obtain essential health services. The need for concern is particularly reinforced by a study of uncompensated care conducted by Frank Sloan and several colleagues. (37a) In that study Sloan determined that a hospital's facility mix has an important effect on its uncompensated care caseload and that obstetrics, and neonatal intensive care, are leading sources of "self pay/no pay" patients. Sloan noted that "[a] hospital which decided to substantially reduce or eliminate its activities in these areas would substantially reduce the institution's charity care - bad debt caseload." Indeed, Sloan found that between 1981 and 1982, fifteen percent of hospitals adopted explicit limits on the amount of charity care they provided. To the extent that obstetrics and neonatology tend to dominate hospitals' uncompensated care caseloads at a time when hospitals are less able and willing to respond to the needs of the medically indigent, policy-makers need to be especially sensitive to maternal and child health needs in fashioning remedies.

3. HOW WELL ARE WE CURRENTLY MEETING THE NEEDS OF MEDICALLY INDIGENT PREGNANT WOMEN AND CHILDREN?

For years, cases have come to our attention that graphically reveal the real-life effects of the statistical portrait set forth above. The following 3 cases (all names have been changed) come from the files of the Office for Civil Rights of the Department of Health and Human Services:

THE WALKERS

Jean Walker, in labor, was rushed one night in early January to a small south-central Tennessee hospital along the Tennessee-Alabama border. Her husband, Edward, was a day laborer who earned just enough money to disqualify them for public assistance. The family had no health insurance.

Mrs. Walker had no physician because the two obstetricians in their county wanted $400 for delivery. Mrs. Walker arrived at the hospital in the middle of the night amidst an ice and rain storm. The hospital staff admitted her to the labor room and got her into hospital clothing. A few minutes later, the nurse came back and told her she was sorry but Mrs. Walker would have to leave because she had no doctor. Mrs. Walker dressed and returned to the waiting room, still in labor. The nurses thought better, readmitted her to the labor room, and undressed her again. The nurses contacted the two local obstetricians in town. The nurses contacted the two local obstetricians in town. Both refused to deliver her because it was late at night, the weather was bad, and she had no money. The nurses told Mrs. Walker to get dressed again. They told her they were very sorry but that she would have to go elsewhere. The Walkers drove 35 miles through the storm to a hospital in Huntsville, Alabama where their baby was delivered.

The Hogans

Frank and Ella Hogan brought their baby to the Ross County Medical Center in Columbus, Ohio, for care. Their desperately ill baby had been examined by a physician at a public clinic in Pike County who immediately referred the Hogans to Ross County so that their baby could be admitted and treated. The Hogans were indigent and had no doctor of their own.

Upon arriving at Ross County, the Hogans were kept waiting in the emergency room for four hours. The baby was finally admitted by a radiologist after the pediatrician on call had refused to admit or treat the baby. The baby died a few hours later without having received medical attention other than that provided by the radiologist.

When asked why he refused to admit the baby, the pediatrician said that he was not going to serve as back-up to any "free-clinic." The physician appeared to have a history of refusing to admit indigent patients.

The Smiths

When she was 8 months pregnant, Marsha Smith of Abingdon, Virginia, was rushed to Johnston Memorial Hospital. She had not seen an obstetrician. There are only two obstetricians in the county and both required payment of $650 before they could see her or deliver her baby. She and her husband could ot afford medical care.

The first time she arrived at Johnston Memorial, she was told she could not be admitted without a personal physician. After a legal services attorney intervened, the hospital admitted and treated her for an acute kidney infection. She was released the following day.

The next day, Mrs. Smith returned to the hospital again in acute pain, sure that she was in premature labor. The Chief of Emergency Services refused her admission saying "she knew she was not supposed to return to that hospital." The physician then chased Mrs. Smith and her husband out to the parking lot, threatening to call the police if they did not leave. He told her that he would not admit her, even if she was in labor.

Mrs. Smith drove twenty miles across the state line to Bristol Memorial Hospital in Bristol, Tennessee. She was hospitalized for five days with a major kidney infection. Remarkably, she delivered a healthy baby a month later at Bristol-Memorial Hospital, which bent the rule against admitting out-of-state residents.

In an effort to more systematically measure the adequacy and scope of state maternal and child health services for medically indigent mothers and children, the CDF health division recently commenced a 23 state survey of public health programs. While the results are still being tabulated, we have been able to conclude preliminarily that not a a single state had the capacity to ensure access to appropriate maternity and pediatric services for women and children living below federal poverty levels. While all of the survey states offer at least some preventive services (such as hearing tests, immunizations, or pap smears) in at least some counties, and while many states and localities have gone to extraordinary lengths to institute special programs for certain high risk populations (such as pregnant women), no state is able to routinely provide or support the range of inpatient and outpatient services recommended by such professional organizations as the American Academy of Pediatrics, The American College of Obstetricians and Gynecologists, the National Perinatal Association, the March of Dimes and other organizations. Some examples of the gap between mothers and children's needs and states' and localities' capacity include the following:

- There are an estimated 90,000 poor pregnant women living in Texas at or below 150% of the federal poverty level. Sixty-one thousand women were seen through health department clinics last year. Medicaid paid for only 14,095 deliveries, however, leaving approximately 36,000 deliveries to a predominantly uninsured population. Many local hospitals in Texas now charge substantial preadmission deposits for a pregnant woman who wishes to register at the hospital for delivery of her child. Preregistration is, of course, crucial, so that a hospital and the attending physician can be alerted as to whether the patient presents a high risk of delivery complications (most of these women have no personal obstetrician to deliver their babies, since they are indigent).

Because the preadmission deposit requirements are so prohibitive, however, a large number of births happen outside of the hospital. In 1982, Texas alone accounted for *one-third* of all out-of-hospital births in the United States. Women who do not deliver at home (unattended by an obstetrician, since they cannot afford one) wait until they are in labor to present themselves at the nearest hospital as an emergency case. Last year, Texas used half its supplemental MCH Block Grant appropriations, *not* to improve preventive services, (approximately 17 of 72 city and county health departments and one regional health department still do not offer *any* maternity care) but to underwrite hospital delivery costs for some of the pregnant women who had no Medicaid. When those monies run out, the delivery program will cease.

- Special infusions of funds in Louisiana through the Title V Improved Pregnant Outcome (IPO) Program and the Fiscal 1983 MCH Block Grant supplemental appropriation made it possible for state and local health officials to deliver important new services to poor women and children. Because of IPO funds, mortality rates in Tangipahoa Parish dropped from 24.9 deaths/1000 live births in 1978 to a provisional rate of 14.9 deaths/1000 live births in 1982. Similarly, clinics throughout the state were able to increase their maternity caseloads by 34% and their pediatric caseloads by 12%. But the IPO and Jobs Act funds are now running out. When they do, the lay outreach workers and extra clinicians who made these services and results possible will be gone.

- In Minnesota, about 51,000 families with children (1/3 of all such families) live below the federal poverty level. Yet Medicaid coverage in Minnesota reached only about 39% of poor children in 1980. Moreover, in 1982, because of the federal budget cuts, the University of Minnesota estimates that more than 13,500 households lost Medicaid eligibility. Since heads of households in these cases tend to work at marginal jobs with little or no employer-paid health insurance, they are often wholly dependant on public health services.

  The state has developed a Community Health Services plan which covers most areas of the state for well child care, public health nursing home visits and health education. Despite these very basic services, state MCH officials report that in rural counties, which comprise 50% of the state, all sick-child and maternity medical services are provided by private physicians. Families are required to make their own arrangements with physicians. In 1980, infant mortality rates in some of these counties were as high as 21 deaths per 1000 live births, twice the national average. A recent University of Minnesota survey found that 200 women choosing out-of-hospital births did so not out of personal preference, but in great measure because of financial considerations.

- In Kansas, 7.6% of all families in the state live in poverty. Yet the state's Maternity and Infant Care Projects reached only 2.7% of women giving birth in 1982. State officials reported incidents in which indigent women were denied prenatal care because of outstanding medical bills. Jobs Act funds were used last year to expand preventive serives in 52 counties that showed the largest numbers of births to poor women in 1982. Even those funds, however, would not cover hospital and obstetrical costs at the time of delivery. County officials do not know what will happen to these modest programs when the Jobs Act monies run out.

4. DO WIDE GAPS IN APPROPRIATE HEALTH CARE COVERAGE FOR PREGNANT WOMEN AND CHILDREN MAKE SENSE?

Nothing makes less sense in either human or fiscal terms than the current gaps in medical coverage among low-income women and children. Maternity and pediatric services are not only effective; they have been shown to be a remarkably cost-effective type of health care investment.

a. The Effectiveness and Cost Effectiveness of Prenatal Care

Through prenatal care, women are linked up with the medical care they and their babies may need. Prenatal care can identify conditions and problems that lead to prematurity and low birthweight among infants. Access to prenatal care is thus the first step toward ensuring a healthy birth outcome:

- Three quarters of the health risks that are associated with low birthweight (the leading cause of infant death and handicapping) can be evaluated in the first prenatal visit, and interventions can be taken to reduce the risks. (38)
- A review of infant deaths among low income mothers found that 26% were preventable. Of these preventable deaths, 1/3 could have been prevented during the prenatal period. The study also found that improved health care for expectant mothers during the last six months of pregnancy would cut in half the mental retardation rate. (39)

- A Colorado study found that women who have complete prenatal care have a prematurity birthrate of 5%; women who receive no care have a prematurity rate of 28%. (40)

- A Missouri study found that white mothers with inadequate prenatal care have a 50% greater prematurity rate than white mothers receiving adequate care. For non-white women the prematurity differential is 15%. (41)

- The California Obstetrical Access Program, initiated in 1979 in response to the inability of poor pregnant women to obtain care, had provided maternity-related services to over 7000 women in the last 3 years. Statewide results at the end of the first year of the project showed low birghweight rates 50% lower than those among comparable infants whose mothers did not participate in the projects. (42)

- A study in Cleveland conducted in the late 1970s found that women who received comprehensive prenatal care at the city's Maternity and Infant Care Project experienced 60% less perinatal mortality and a 25% lower rate of preterm deliveries than comparable women not enrolled in the project. (43)

- The New York City Comprehensive Maternity and Infant Care Project yielded significant decreases in infant mortality rates in the areas served by the project, and neonatal mortality rates were over 20% lower for MIC participants. (44)

- Within a two-year period, the Providence, Rhode Island, Maternity and Infant Care Project resulted in a 25% decline in infant mortality rates in the areas it served. (45)

- Studies of the impact of necessary intensive care for newborns have shown that these services not only save lives but reduce by 2 to 3 times the percent of high-risk infants suffering from definite abnormal physical or mental development. (46)

Moreover, comprehensive maternity care is extremely cost-effective:

- The California Department of Consumer Affairs found a savings of $1.4 million per 1000 women served over a 5-year period in a perinatal care project, versus costs per 1000 women where no such care was available. The net 5-year perinatal program costs for 1000 women totaled $750,000. For women who did not receive such care, costs were $4.6 million. The bases for the cost reduction included: increased birth weight among babies born to patients; reduced prematurity; reduced costs for child protective services; reduced costs for special education and similar services; and reduced costs for emergency room and hospital care. (47)

- Michigan state officials examining 9,752 infants who were born at low birthweight and 6000 babies who received care in newborn intensive care units, estimated that, with good prenatal care, at a minimum 25% (1500 infants) would not have required such services. The state then determined that, while the cost of providing prenatal care to all 14,000 uninsured women was $4.9 million, the cost of providing neonatal care to the 1500 infants was $30 million. Thus for every dollar spent by the state on prenatal care, it would save $6.12. (48)

- Officials at the Lea County, New Mexico, High Risk Perinatal care project found that women who received adequate prenatal care showed the following characteristics:

  8% low birthweight
  15% resulting in maternal complications

  Without adequate prenatal care, women showed the following outcomes:

  16% low birthweight
  30% resulting in maternal complications

  By spending $64,000 on maternity care, the low birthweight rate would be cut in half, and savings of $310,000. Thus, for every dollar spent on maternity care, researchers found five dollars in savings. (49)

- The Colorado health department found that only 54% of low income women begin prenatal care in the first trimester of pregnancy, as opposed to 80% of nonpoor women. By providing adequate prenatal care to poor women, the state anticipated that 343 premature births could have been prevented (based on a 12% prematurity birthrate among 8675 live births in 1975).

  Based on a 1977 study, the state estimated that among low birthweight survivors, lifetime costs were $20,000 per child. Moreover, specialized education and institutional services were required for 4% of low birthweight babies (between 3 and 5.5 pounds) and for 25% of very low birthweight babies (weighing under 3 pounds). For each of the babies with special problems, the cost would be approximately $123,000/child.

  Based on the estimated costs of prematurity, the health department concluded that, for each $1.00 spent on prenatal care, $9.00 would be saved. If all longterm costs were included, the cost/benefit ratio would escalate to $11.00 saved for every $1.00 spent. (50)

D. The Effectiveness and Cost Effectiveness of Pediatric Care

- A Texas study which examined the costs and benefits of Medicaid preventive care (vision screening, hearing screening, preventive dental care, and identification of congenital malformations) showed that for each state dollar spent, more than $8 was saved in the long term costs and in the income loss avoided. (51)

- A 1977 General Accounting Office report to the Congress found the cost of genetic screening at birth plus early treatment for seven common disorders was less than one-eighth the projected cost of caring for an impaired child over a lifetime, even without taking into account the extent to which inflation would drive up long term costs. (52)

- A study by the Center for Disease Control showed that $180 million spent on a measles vaccination program between 1966 and 1974 saved $1.3 billion in medical care and long term care by reducing deafness, retardation, and other problems. (53)

- In North Dakota, total Medicaid expenditures per child were 36 percent to 44 percent lower for children who were screened than for those who were not. Expenditures for inpatient hospital services were 47-57 percent lower for those who had been screened. (54)

- In Baltimore, Maryland, where four preventive health programs were established in the most underserved areas of the city, the incidence of rheumatic fever was reduced by 60 percent among children in the census tracts eligible for any of the programs, while in the surrounding areas its incidence increased by 20 percent. (55)

- A recent federal study demonstrated that among low-income families with access to comprehensive primary and preventive services, dramatic reductions in hospitalization costs -- some 25 percent below hospitalization rates for persons without access to such care -- are noted. (56)

- A Pennsylvania study of that state's Medicaid EPSDT program found that children participating in the comprehensive preventive health project had 30 percent fewer abnormalities on rescreening with attendant cost-savings. (57)

- An evaluation of the Medicaid EPSDT program by the State of Missouri found that participating children had annual medical costs 16 percent lower than those not participating ($253.79 for children in EPSDT versus $318.58 in expenditures for non-participants). (58)

- A New York survey of Suffolk County Medicaid children found that those receiving continuous, comprehensive preventive care had annual costs of $312.74. Those who did not have annual costs of $484.39. (59)
- A study conducted by the American Academy of Pediatrics shows a decrease in annual costs for children receiving continuing care. Those receiving the least amount of care had annual costs of $638.23; those receiving the most care cost $378.47. (60)
- An evaluation by Michigan of that state's Medicaid EPSDT program found that, among children participating continuously in the program not only did they display increasingly fewer health problems upon each rescreening but also, that medical costs for program participants were 7% lower than medical costs for non-EPSDT participants when program costs were considered. (61)

RECOMMENDATIONS

The issue of medical indigency is not only an extremely serious one for the poor, but is also a substantial threat to the health care system that cares for the poor. Many of the public and community clinics and institutions treating the poor are under serious financial stress, chiefly because of the combined effects of the large medically indigent population they treat and shortfalls among various public and private payers for their insured patients. (62) Moreover, as noted above in the discussion of cost-effectiveness literature, medical indigency ultimately represents an enormous longterm drain on federal, state and local resources.

There are two basic approaches to dealing with the problem. Neither is exclusive. First, we need to improve public and private health insurance programs in order to generate a health care financing system that insures individuals for basic services. In the case of pregnant women and children, insurance reforms may particularly modest in comparison to the longtern costs associated with failing to make such reforms. Second, direct subsidies to public and community institutions providing a large volume of care for the uninsured are needed, in order to promote targeted improvements and services.

a. Health Insurance Reforms

As noted above, children in uninsured families can be found in a variety of family settings, including unemployed and employed households, as well as households unconnected to the workplace. There are several possible approaches to insurance reform:

Medicaid: Research has shown a strong relationship between Medicaid coverage and health status. The Medicaid EPSDT studies noted above, have demonstrated a relationship between program participation and child health outcomes. Other studies have shown similar results. The Urban Institute found a significant correlation between the availability of Medicaid coverage for pregnant women and imporvements in states' neonatal mortality rates. (63) The California Obstetrical Access Project which led to a 50% decline in low birthweight infants among participating women, involved the provision of comprehensive Medicaid coverage for an array of prenatal care for women enrolled in the project. (64) Additionally, researchers in California examining the impact of Medicaid on infant death rates, found a major relationship between a 50% decline in perinatal death rates from 1968-1978 in that state and Medicaid coverage for low income women. By 1978, 10 years after Medicaid was implemented, researchers found access to prenatal care greatly increased. Standardized mortality rates for infants born to poor women eligible for Medicaid were 4-5% lower than among low income infants whose mothers were not insured. (65)

Medicaid benefits for pregnant women and children also saves money. For example, the California Obstetrical Access Project provided comprehensive Medicaid maternity coverage for pregnant women. The study found that, because low birthweight rates for project participants were 50% less than among those not participating in the program, the savings from reduced need for neonatal intensive care and rehospitalization in the first year of life resulted in a savings of $4.00 for every Medicaid dollar spent on maternity care. (66) Similarly, a study done by the Texas Department of Human Resources, after looking at 1981 data on over 9000 births, concluded that Medicaid-eligible pregnant women had $210 fewer birth-related expenses than mothers who were ineligible for Medicaid at the time of delivery. Women receiving Medicaid during pregnancy were of course eligible for prenatal care and other medical care to maintain their health. Medicaid-ineligible women were not only less likely to receive prenatal care but were also less likely to receive needed basic medical attention and were therefore at heightened risk for complications arising from such untreated conditions as hypertension or diabetes. (67)

Despite the fact that Medicaid has made a major contribution to improving the health status among the poor, the program still falls far short of the need. While Congress enacted crucial improvements this past summer that extended benefits to an additional half million children and 200,000 pregnant women, nearly 30 states still fail to provide Medicaid to children ages 5-18, and more than 30 states fail to provide coverage to married pregnant women in two-parent families, no matter how poor they are. Moreover, since eligibility is tied to welfare eligibility, coverage is available only for families meeting state welfare financial eligibility criteria -- frequently less than half the federal poverty rate. Finally, as noted previously, numerous states impose substantial restrictions on coverage of vital services.

One way to reach more medically indigent families, therefore, is to improve Medicaid. Specific options might include: establishment of uniform financial eligibility criteria under the program that are tied to the federal poverty standard, with benefits available to families with incomes slightly over the federal poverty level in accordance with a sliding fee scale. Insofar as maternity and pediatric services are concerned, the cost of such an expansion would be relatively modest. Complete prenatal and delivery care for a pregnant woman currently costs about $2,000 under Medicaid. (68) Pediatric costs are about $600 per child. (69) The development of a uniform service package could also eliminate some of the most significant state-to-state disparities that currently exist.

Medicare: As noted previously, hundreds of thousands of widowed families with minor children currently receive Social Security Survivor's benefits but are ineligible for Medicare. For these families, it might be possible to develop a special Medicare program with governmentally subsidized premiums. Such a program would enable survivor families to purchase modest but crucial packages of health services for themselves and their children. Such a package (or, similarly, a Medicaid package furnished in accordance with a sliding fee) could be made available to unemployed families.

Private Insurance: When governmental expenditures on health care for the noninstitutionalized population is calculated to include tax expenditures, the government spends about the same on the poor and near-poor as it does on the middle and high income population.(70) Yet, as noted above, employer based health insurance may be seriously deficient for dependents of workers. Even though employer-purchased health insurance accounts for 85% of all private insurance purchased in the United States, (71) many workers are completely uncovered. Other workers may be unable to purchase family coverage. When they do, workers may discover that their plans are seriously deficient insofar as maternal and child health needs are concerned. CBO estimated in 1978 that if all workers and their dependents had employer-based coverage, and if all self-employed persons were covered, then the number of uncovered Americans would drop by half. (72)

In addition to expanding public health insurance programs, we must develop approaches to employer-based health coverage that assist poorer workers in purchasing family coverage. The Administration and Congress should also consider establishing minimum standards for employer-purchased health insurance to eliminate the serious gaps in maternal and child health coverage.

b. Support for Institutions Serving the Uninsured

Even with more comprehensive insurance, there will continue to be a need to directly support institutions serving the uninsured and underinsured, since operating such institutions may require certain types of expenditures that are not adequately financed through insurance (e.g., establishment of clinics, modernization of facilities and equipment and so forth). While such subsidies are crucial, we believe, for two reasons, that they should not be allowed to become the central thrust in the government's effort to grapple with the problem of medical indigency. First, the medically indigent, especially children and pregnant women, generally require services that are not appropriately or cost-effectively provided in an institutional setting. Yet uncompensated care remedies that take the form of direct subsidies to institutions threaten to perpetuate fragmented and inappropriate patterns of care. If we have learned nothing else in the past 20 years, it is that we end up with the type of health system that we finance. If our approach to uncompensated care is institution-based rather than individual-based, I fear that we will only perpetuate an already strong institutional bias.

Second, health financing reforms that deal with the medical problem, sub rosa, through uncompensated care pools, rather than directly, as in the case of health insurance reform, may raise serious legal and equitable concerns. Who will control the eligibility determination process? How will benefits be meted out? What happens if a pool is inadequate to furnish for the uninsured the scope of care available to the insured? What do "bad debt pools" say about how government perceives its role in allocating health care resources, especially if we purport to believe that need, rather than ability to pay, is what should determine access to health care?

In 1983 the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research issued its seminal report, Securing Access to Health Care. In that report the Commission concluded that society has an ethical obligation to ensure that all its member have access to basic health services and that the ultimate responsibility for ensuring that the obligation is met lies with government. We hope that that report and its conclusions will guide the Committee in determining the appropriate remedy for the nation's medical indigency problem. Thank you.

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